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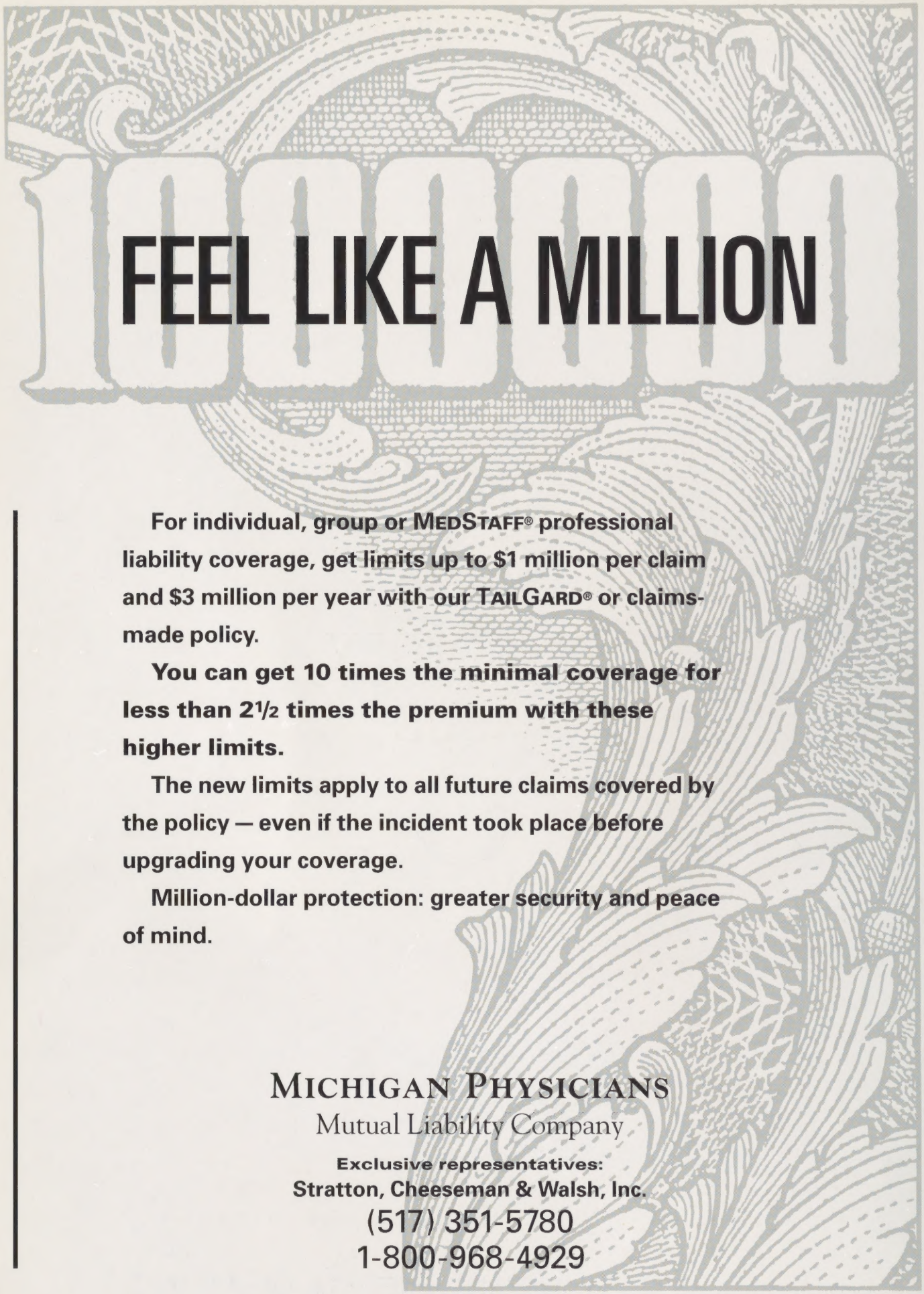
MICHIGAN MEDICINE

JANUARY 1993
VOL. 92, NO. 1

Award-Winning Journal of the Michigan State Medical Society

1993 MSMS DIRECTORY ISSUE

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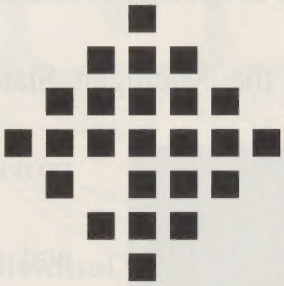


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JANUARY 1993 VOLUME 92, NO. 1
Award-Winning Journal of the Michigan State Medical Society

1993 MSMS DIRECTORY ISSUE

This month's issue of Michigan Medicine serves as the official directory of MSMS members for 1993. Included in the directory are three listings – a complete alphabetical list of MSMS members, which begins on page 13; a list of MSMS members according to their component society memberships, which begins on page 71; and a list of MSMS members by specialty, which begins on page 275. Rounding out the directory is an MSMS reference guide, which begins on page 337. We hope you find this directory useful.

DEPARTMENTS

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In next month's issue:
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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Michigan Medicine (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published once each month, 12 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $100.00 (includes weekly *Medigram* newsletter); single copies, $3.00: Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news and exchanges should be addressed to Betty McNerney, advertising to Pat Horan, and address changes to Kathy Hagen, Michigan State Medical Society, P.O. Box 950, East Lansing, Michigan 48826-0950. Phone 517-337-1351.

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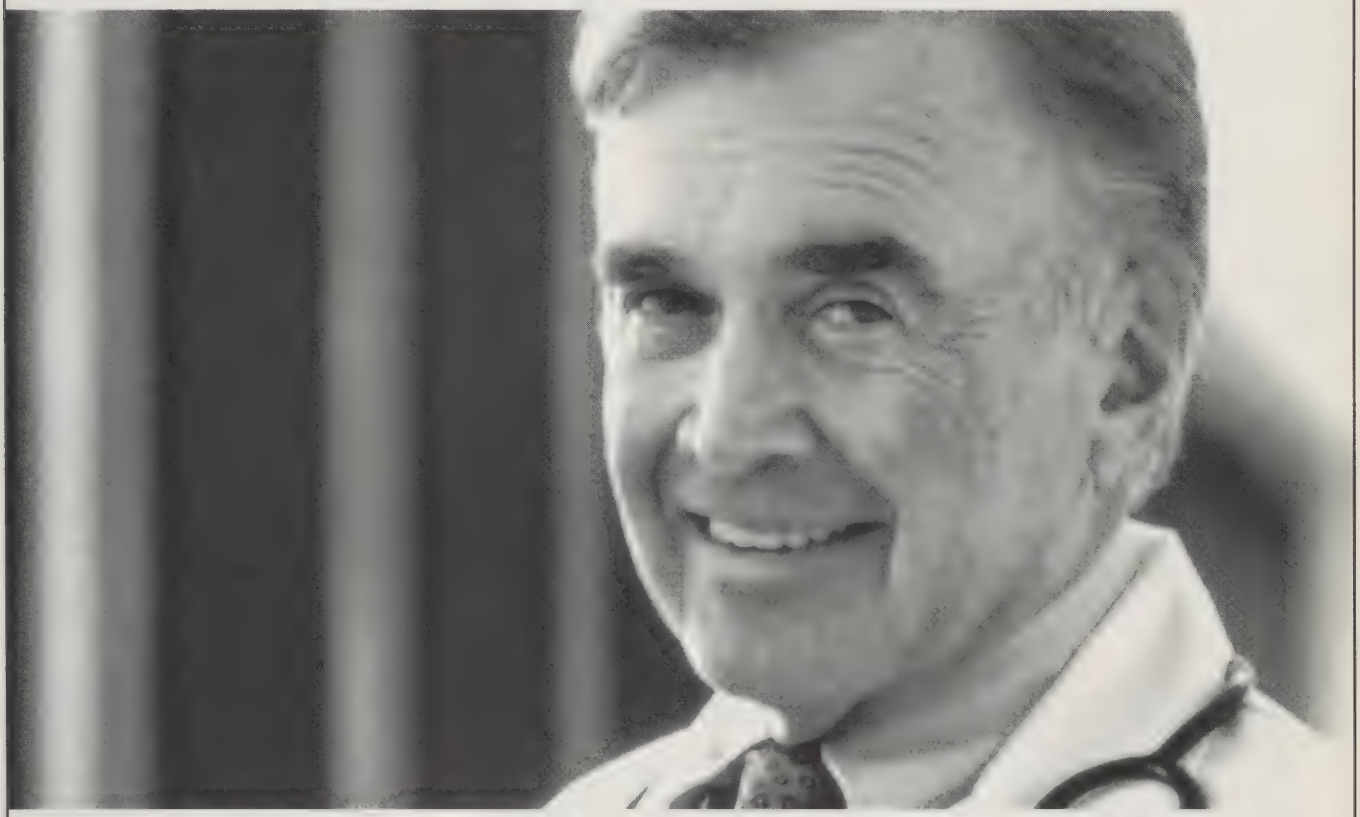
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1993 MSMS DIRECTORY ISSUE



This MSMS membership directory provides three different listings. Beginning on page 13 is a complete alphabetical list of MSMS members. Each name is followed by a letter code which refers to a membership classification, a specialty code, and then the county society code number, which serves as a cross reference to help the user refer to the assigned county society.

Beginning on page 73 is a list of MSMS members according to their county society memberships. County society members appear in alphabetical order and with mailing addresses and telephone numbers (where provided) as of December 31, 1992. The MSMS county society code number appears with the heading for each county society.

Beginning on page 275 is a list of MSMS members by specialty. Each name is followed by a county society code number, which serves as a cross reference to help the user refer to the assigned county society.

A reference guide to MSMS and other state medical organizations and agencies appears in the back of this directory. On the following page are guides to membership classifications and county society codes. Specialty society codes are explained on page 13.

Guide to County Societies and County Society Codes

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Gratiot	(074)	97
Hillsdale	(078)	98
Houghton	(082)	98
Huron	(086)	99
Ingham	(090)	100
Ionia	(094)	110
Iosco	(095)	110
Iron	(054)	84
Isabella	(096)	111
Jackson	(098)	112
Kalamazoo	(102)	114
Kalkaska	(150)	154
Kent	(106)	124
Keweenaw	(082)	98
Lake	(142)	153
Lapeer	(110)	140
Leelanau	(070)	94
Lenawee	(114)	141
Livingston	(118)	142
Luce	(122)	143
Mackinac	(042)	82
Macomb	(126)	143
Manistee	(130)	150
Marquette	(134)	150
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Mecosta	(142)	153
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St. Joseph	(198)	202
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Schoolcraft	(204)	203
Shiawassee	(206)	203
Tuscola	(210)	204
Van Buren	(214)	204
Washtenaw	(218)	205
Wayne	(222)	217
Wexford	(226)	272

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Guide to help locate cities within counties

This guide matches Michigan doctor's communities with their counties.

A

Ada (Kent)
Addison (Lenawee)
Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Allendale (Ottawa)
Allen Park (Wayne)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)
Ashley (Gratiot)
August (Kalamazoo)

B

Bad Axe (Huron)
Baldwin (Lake)
Bangor (Van Buren)
Baraga (Baraga)
Bark River (Delta)
Battle Creek (Calhoun)
Bay City (Bay)
Bear Lake (Manistee)
Belding (Ionia)
Bellaire (Antrim)
Belleville (Wayne)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Center (Berrien)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Beulah (Benzie)
Big Rapids (Mecosta)
Birch Run(Saginaw)
Birmingham (Oakland)
Blanchard(Isabella)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Bloomingdale (Van Buren)
Boyne City (Charlevoix)
Branch (Mason)
Breckenridge (Gratiot)
Bridgeport (Saginaw)
Bridgman (Berrien)
Brighton (Livingston)
Bronson (Branch)
Brooklyn (Jackson)
Brown City (Sanilac)
Buchanan (Berrien)
Byron Center (Kent)

C

Cadillac (Wexford)
Caledonia (Kent)
Calumet (Houghton)
Camden (Hillsdale)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Caseville (Huron)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Centre Line (Macomb)
Centreville (St. Joseph)
Champion (Marquette)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Chassell (Houghton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)
Clarkston (Oakland)
Clawson (Oakland)
Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coleman (Midland)
Coloma (Berrien)
Colon (St. Joseph)
Columbiaville (Lapeer)
Comstock Park (Kent)
Concord (Jackson)
Constantine (St. Joseph)
Coopersville (Ottawa)
Corunna (Shiawassee)
Croswell (Sanilac)
Crystal Falls (Iron)
Custer (Mason)

D

Daggett (Menominee)
Davison (Genesee)
Dearborn (Wayne)
Dearborn Heights (Wayne)
Decatur (Van Buren)
Deckerville (Sanilac)
Deerfield (Lenewee)
Delton (Barry)
Detroit (Wayne)
DeWitt (Clinton)
Dexter (Washtenaw)
Douglas (Allegan)
Dowagiac (Cass)
Drayton Plains (Oakland)
Drummond Island (Chippewa)
Dundee (Monroe)
Durand (Shiawassee)

E

Eagle Harbor (Keweenaw)
East Detroit (Macomb)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Edmore (Montcalm)
Edwardsburg (Cass)
Elk Rapids (Antrim)
Elkton (Huron)
Eloise (Wayne)
Elsie (Clinton)
Engadine (Mackinac)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

F

Fairgrove (Tuscola)
Farmington (Oakland)
Farwell (Clare)
Fennville (Allegan)
Fenton (Genesee)
Fenwick (Montcalm)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Fowlerville (Livingston)
Frandor (Ingham)
Frankenmuth (Saginaw)
Franklin (Oakland)
Fraser (Macomb)
Freeland (Saginaw)
Fremont (Newaygo)

G

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)
Gladwin (Gladwin)
Glen Arbor (Leelanau)
Gobles (Van Buren)
Goodrich (Genesee)
Grand Beach (Berrien)
Grand Blanc (Genesee)
Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Marais (Alger)
Grand Rapids (Kent)
Grandville (Kent)
Grant (Newaygo)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Ile (Wayne)
Grosse Pointe Farms (Wayne)
Grosse Pointe Shores (Wayne)
Grosse Pointe Woods (Wayne)
Gwinn (Marquette)

H

Hamburg (Livingston)
Hamilton (Allegan)
Hamtramck (Wayne)
Hancock (Houghton)
Hanover (Jackson)
Harbert (Berrien)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Harper Woods (Wayne)
Harrison (Clare)
Harrisville (Alcona)
Harsens Island (St. Clair)
Hart (Oceana)
Hartford (Van Buren)
Haslett (Ingham)
Hastings (Barry)
Hazel Park (Oakland)
Hemlock (Saginaw)
Hessel (Mackinac)
Hickory Corners (Barry)
Highland (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Holt (Ingham)
Homer (Calhoun)
Horton (Jackson)
Houghton (Houghton)
Howell (Livingston)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

I

Imlay City (Lapeer)
Indian River (Cheboygan)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

J

Jackson (Jackson)
Jamestown (Ottawa)
Jonesville (Hillsdale)

K

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Keego Harbor (Oakland)
Kent City (Kent)
Kinde (Huron)
Kingsford (Dickinson)

L

Lake City (Missaukee)
Lakeland (Livingston)

Lake Odessa (Ionia)
Lake Orion (Oakland)
Lakeview (Montcalm)
Lambertville (Monroe)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
La Salle (Monroe)
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Laurium (Houghton)
Lawrence (Van Buren)
Lawton (Van Buren)
Leonidas (St. Joseph)
Leslie (Ingham)
Lincoln Park (Wayne)
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Ludington (Mason)
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Luzerne (Oscoda)

M

Mackinac Island (Mackinac)
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Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manitou Beach (Lenawee)
Marcellus (Cass)
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Marion (Osceola)
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Marquette (Marquette)
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Nashville (Barry)
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Onsted (Lenawee)
Ontonagon (Ontonagon)
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Ossineke (Alpena)
Otisville (Genesee)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
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P

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Pinckney (Livingston)
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Plainwell (Allegan)
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Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Romulus (Wayne)
Roscommon (Roscommon)
Rosebush (Isabella)
Roseville (Macomb)
Royal Oak (Oakland)

S

Saginaw (Saginaw)
Sagola (Dickinson)
Saline (Washtenaw)
Sandusky (Sanilac)
Sanford (Midland)
Saranac (Ionia)
Saugatuck (Allegan)
Sault Sainte Marie (Chippewa)
Sawyer (Berrien)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Selfridge AFB (Macomb)
Shelby (Oceana)
Shelbyville (Allegan)
Sidney (Montcalm)
Southfield (Oakland)
Southgate (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spaulding (Menominee)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
St. Charles (Saginaw)
St. Clair (St. Clair)
St. Clair Shores (Macomb)
Stephenson (Menominee)
Sterling Heights (Macomb)
St. Ignace (Mackinac)
St. James (Charlevoix)
St. Johns (Clinton)
St. Joseph (Berrien)
St. Louis (Gratiot)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sunfield (Eaton)
Suttons Bay (Leelanau)
Swartz Creek (Genesee)

T

Tawas City (Iosco)
Taylor (Wayne)
Tecumseh (Lenawee)
Temperance (Monroe)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)
Troy (Oakland)
Trufant (Montcalm)

U

Ubly (Huron)
Union City (Branch)
Union Lake (Oakland)
Utica (Macomb)

V

Vandalia (Cass)
Vassar (Tuscola)
Vicksburg (Kalamazoo)
Vulcan (Dickinson)

W

Wakefield (Gogebic)
Walkerville (Oceanic)
Walled Lake (Oakland)
Warren (Macomb)
Waterford (Oakland)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
Weidman (Isabella)
Wellston (Manistee)
West Branch (Ogemaw)
Westland (Wayne)
Westphalia (Clinton)
White Cloud (Newaygo)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
White Pine (Ontonagon)
Whitmore Lake (Washtenaw)
Williamston (Ingham)
Wixom (Oakland)
Woodhaven (Wayne)
Wurtsmith AFB (Oscoda)
Wyandotte (Wayne)
Wyoming (Kent)

Y

Yale (St. Clair)
Ypsilanti (Washtenaw)

Z

Zeeland (Ottawa)

Alphabetical Listing of MSMS Members

** Asterisk beside name denotes AMA membership*

Specialty codes			
A	Allergy	**GO**	Gynecologyical Oncology
ADL	Adolescent Medicine	**GP**	General Practice
AI	Allergy & Immunology	**GPM**	General Preventive Medicine
AM	Aerospace Medicine	**GS**	General Surgery
AN	Anesthesiology	**GYN**	Gynecology
AS	Abdominal Surgery	**HEM**	Hematology
ATP	Anatomic Pathology	**HNS**	Head & Neck Surgery
BLB	Bloodbanking Pathology	**HS**	Hand Surgery
CCM	Critical Care Medicine	**ID**	Infectious Diseases
CD	Cardiovascular Diseases	**IG**	Immunology
CDS	Cardiovascular Surgery	**IM**	Internal Medicine
CHN	Child Neurology	**IP**	Immunopathology
CHP	Child Psychiatry	**LM**	Legal Medicine
CLP	Clinical Pathology	**MFM**	Maternal and Fetal Medicine
CMP	Chemical Pathology	**MM**	Medical Microbiology
CRS	Colon & Rectal Surgery	**N**	Neurology
D	Dermatology	**NA**	Neuropathology
DIA	Diabetes	**NEP**	Nephrology
DLI	Diagnostic Laboratory Immunology	**NM**	Nuclear Medicine
DMP	Dermatopathology	**NPM**	Neonatal-Perinatal Medicine
DR	Diagnostic Radiology	**NR**	Nuclear Radiology
EM	Emergency Medicine	**NS**	Neurological Surgery
END	Endocrinology	**NTR**	Nutrition
FOP	Forensic Pathology	**OBG**	Obstetrics & Gynecology
FP	Family Practice	**OBS**	Obstetrics
FPS	Facial Plastic Surgery, Otolaryngology	**OM**	Occupational Medicine
GE	Gastroenterology	**ON**	Oncology
GER	Geriatrics	**OPH**	Ophthalmology
		ORS	Orthopedic Surgery
		OS	Other Specialty
		OTO	Otolaryngology
		P	Psychiatry
		PA	Clinical Pharmacology
		PD	Pediatrics
		PDA	Pediatric Allergy
		PDC	Pediatric Cardiology
		PDE	Pediatric Endrocrinology
		PDR	Pediatric Radiology
		PDS	Pediatric Surgery
		PH	Public Health
		PHO	Pediatric Hematology-Oncology
		PM	Physical Medicine & Rehabilitation
		PNP	Pediatric Nephrology
		PS	Plastic Surgery
		PTH	Pathology
		PUD	Pulmonary Diseases
		PYA	Psychoanalysis
		PYM	Psychosomatic Medicine
		R	Radiology
		REN	Reproductive Endocrinology
		RHU	Rheumatology
		RIP	Radioisotopic Radiology
		RO	Radiation Oncology
		TRS	Traumatic Surgery
		TS	Thoracic Surgery
		U	Urological Surgery
		VS	Vascular Surgery

Note: No code will appear for those physicians who have not designated a specialty.

A

* Adnan G. Abbasi, MD	CRS	174
* Ali A. Abbasi, MD	END	174
Saadat Abbasi, MD	PD	102
* R. Roderic Abbott, MD	IM	062
Mushtak Abbou, MD	OBG	222
* Martin M. Abbrecht, MD	D	174
* Marwan Abdul-Samad, MD	PD	142
* Tama D. Abel, MD	FP	218
* Eduardo C. Abellana, MD	AN	222
Gerald J. Aben, MD	IM	222
* Gerald R. Aben, MD	DR	090
Reza Abghari, MD	R	222
Victor A. Abiragi, MD	IM	222
* Elie D. Aboulafia, MD	CDS	222
Joseph P. Abraham, MD	HEM	222
Thomas A. Abraham, MD	IM	102
* Saliem M. Abrahams, MD	AN	174
Gary W. Abrams, MD	OPH	174
Lawrence D. Abramson, MD	IM	218
* Samuel M. Abramson, MD	PD	222
Ahmad Abu-Rashed, MD	IM	222
Yousif A. Abubakr, MD	IM	174
* Romulo T. Abueva, MD	AN	102
Mostafa I. Abuzeid, MD	OBG	062
Rukmani Achari, MD	GP	222
* Chaitanya N. Acharya, MD	PUD	106
Siddhartha A. Acharya, MD	IM	026
Sabah E. Acho, MD	AN	174
* Mohan V. Achwal, MD	AN	062
Glen N. Ackerman, MD	N	090
James R. Acocks, MD	PUD	134
Brian A. Adamczyk, MD	FP	098
Gerald D. Adamian, MD	P	222
* Christine Adamick		222
Albert C. Adams, MD	FP	062
Charles L. Adams, MD	TS	162
Ellis W. Adams, MD	PD	098
Frederick M. Adams, MD	PD	174
* James B. Adams, MD	OBG	154
* James L. Adams, MD	OPH	218
James R. Adams, MD	GP	222
* Robert P. Adams, MD	FP	118
Vincent B. Adams, MD	FP	222
* Carolyn J. Adamski		090
Elizabeth H. Adamson, MD	AN	142
* Adelto N. Adan, MD	IM	154
Rafael Addiego, MD	OPH	090
James R. Addison, MD	EM	134
* William G. Addison, MD	OBG	134
* John R. Addy, MD	OBG	090
* Salah K. Adel, MD	OBG	222
* Anthony A. Adeleye, MD	U	222
* Brian D. Adelman, MD	OBG	174
* Bruce T. Adelman, MD	AN	090
* Marc H. Adelman, DO	OBG	174
Scott H. Adelman, MD	CD	090
* Susan H. Adelman, MD	PDS	222
* Irwin P. Adelson, MD	P	174
* Seymour S. Adelson, MD	IM	174
* E. Stanton Adkins, MD	PDS	222
Dorit D. Adler, MD	DR	218
Edward W. Adler, MD	IM	174
* Larry A. Adler, MD	GE	218
* Ram Advani, MD	PTH	106
Bassam A. Afaneh, MD	PD	062
* Nancy Afr		218
* George S. Afram		222
* Leandro F. Africa, MD	TS	126
Mehmet C. Agabigum, MD	OTO	062
Manoochehr K. Agah, MD	PD	174
* Deepak Agarwal, MD	R	190
* Renu F. Agarwal, MD	IM	190
* Harvey G. Ager, MD	P	174
* Kirk J. Agerson, MD	FP	106
Alka Aggarwal, MD	FP	222
Inderjit Aggarwal, MD	IM	222
Kewal K. Aggarwal, MD	IM	174
Satinder K. Aggarwal, MD	IM	222
Verinder K. Aggarwal, MD	IM	222
* Andrew M. Agosta, MD	OBG	190
Atul C. Agrawal, MD	GS	086
Ram N. Agrawal, MD	GS	098
Antonio A. Aguirre, MD	FP	222
Soudabeh Ahadi, MD	OBG	158
* Faris Ahmad		222
* Anwar Ahmad, MD	R	026
* Asir U. Ahmad, MD	IM	174
* Busharat Ahmad, MD	OPH	158
* Fazal Ahmad, MD	IM	174
* Iftiker K. Ahmad, MD	IM	090
Khurshid Ahmad, MD	TS	222
Munawar Ahmad, MD	P	154
* Sohail I. Ahmad, MD	P	194
* Yasmeen A. Ahmad, MD	PD	222
Zaheer G. Ahmad, MD	IM	222
Jalal U. Ahmed, MD	P	090
Kaleem Ahmed, MD	IM	222
* Mosharraf U. Ahmed, MD	IM	174
* Muhammad K. Ahmed, MD	PD	030
* Sajida A. Ahmed, MD	OBG	096
Sylvia E. Ahronheim, MD	OS	098
Donald J. Aiken, MD	FP	090
* Steven A. Aiken, MD	FP	222
* Timothy B. Aiken, MD	OPH	194
* James T. Aills, MD	P	062
* Robert P. Ainsworth, MD	R	190
James J. Aiuto, MD	IM	222
* Michael D. Aja, MD	TRS	070
Edward P. Ajemian, MD	U	102
Nancy A. Ajemian, MD	FP	222
Gurjit S. Ajimal, MD	AN	222
Mohamed K. Ajjour, MD	IM	222
* Elizabeth A. Ajlouni, MD	RO	218
Isa S. Ajlouni, MD	GP	222
* Victor C. Ajluni		222
Roger M. Ajluni, MD	IM	222
Jamal U. Akbar, MD	R	062
* Raana W. Akbar, MD	PD	190
Syed S. Akbar, MD	IM	222
* Waheed Akbar, MD	ORS	190
Jawaid Akhtar, MD	CRS	194
Syed S. Akhtar, MD	GS	190
Hussein Z. Akl, MD	IM	214
Mohammed W. Al-Ameri, MD	PUD	174
Ziad Al-Amiri, MD	DR	190
M. Rida Al-Ansari, MD	U	222
Mowafak S. Al-Asbahi, MD	GE	222
Imad Al-Azem, MD	GP	222
Mohamed W. Al-Azem, MD	R	078
M. Said Al-Beiruti, MD	PTH	106
Samir Al-Hadidi, MD	GE	126
Nabil Z. Al-Hourani, MD	IM	222
* Mufid B. Al-Najjar, MD	P	174
* Muhsin M. Al-Rawi, MD	IM	174
* Silvio Aladjem, MD	OBG	102
* Danish A. Alamy, MD	NPM	062
Dirk H. Alander, MD	ORS	106
* Sarah A. Alander, MD	PD	106
* Hashim M. Alani, MD	PS	174
Emil J. Alban, MD	OBG	222
A. P. Albarran, MD	P	222
* Joe Alberding, MD	FP	102
George D. Albers, MD	OTO	106
Millard J. Albers, MD	OBG	190

Alphabetical Listing of MSMS Members

** Asterisk beside name denotes AMA membership*

* Robert P. Albers, MD	GS	186
* Donald G. Albert, MD	IM	174
* William C. Albert, MD	OPH	174
* Robert D. Albertson, MD	IM	098
Albert J. Albrecht, MD	U	222
Roxie M. Albrecht, MD	GS	106
* Anthony L. Alcantara, MD	DR	222
* Elsa Alcantara, MD	IM	222
Lucilo C. Alcantara, MD	GS	222
* Cesar V. Alcid, MD	AN	062
* Enas Aldabbagh		222
Leonard C. Aldrich, MD	GP	082
Leslie B. Aldrich, MD	IM	218
Charles W. Aldridge, MD	OBG	106
* Scott T. Aldridge, MD	FP	042
* 1 S. Alexander, MD	GE	170
* Arden G. Alexander, MD	IM	162
Cornelius A. Alexander, MD	GS	102
* Don K. Alexander, MD	CD	218
* Gaylord D. Alexander, MD	AN	222
* Jody L. Alexander, MD	OBG	218
Leonard C. Alexander, MD	IM	222
Thomas J. Alexander, MD	GE	174
Anastasios Alexiou, MD	N	218
Barry H. Alford, MD	GP	218
Stanley Alfred, MD	D	062
* George D. Alger, MD	OM	102
Abd A. Alghanem, MD	GS	062
* Patrick C. Alguire, MD	IM	090
* Thomas F. Alguire, MD	IM	186
* Taufiek Alhadi, DO	AN	222
* Max M. Ali, MD	GS	222
S. Akram Ali, MD	GS	194
Shafqat Ali, MD	IM	222
Ali A. Aliasgharpour, MD	IM	158
* Peter Aliferis, MD	PTH	014
Minda P. Alimario, MD	PD	126
* Solon L. Alimario, MD	IM	126
A. E. Alimboyoguen, MD	GP	062
* John L. Alipit, MD	GS	078
* Denis R. Alix, MD	GS	106
* C. Robert Alkema, MD	PD	162
H. Dale Alkema, MD	U	102
* Abdul H. Alkhafaji, MD	GS	174
* Robert D. Allaben, MD	GS	222
Azmy A. Allam, MD	IM	206
* Christian E. Allan, MD	OBG	096
* Monica Y. Allen		222
* Duane M. Allen, MD	OM	190
* J. Scott Allen, MD	P	174
* Jacqueline S. Allen, MD	OBG	102
Jeffrey L. Allen, MD	FP	154
John V. Allen, MD	FP	222
* Richard H. Allen, MD	ORS	034
Richard J. Allen, MD	PD	218
* Richard J. Allen, MD	FP	214
Robert M. Allen, MD	IM	026
Roger K. Allen, MD	D	090
* Thomas M. Allen, MD	ORS	118
* William T. Allen, MD	PUD	218
* William W. Allen, MD	FP	102
Harry D. Allis, MD	ORS	090
Lyle M. Allis, MD	P	218
Hugh R. Allott, MD	EM	042
* Edgar L. Allport, MD	PS	190
Isidro C. Almeda, MD	GS	150
S. P. Almeida, MD	GS	062
Neil H. Alperin, MD	RHU	126
E. Bryce Alpern, MD	PD	222
G. Ann Alpern, MD	PTH	218
Edward Alpert, MD	A	126
Sam Alpiner, MD	GP	222
* Siraj N. Alseri, MD	AN	218
Adnan M. Alshabkhoun, MD	IM	174
* Debra A. Alspector		222
* Jules Altman, MD	D	126
* Evelyn D. Alumit, MD	IM	062
Hernan R. Alvarez, MD	CD	222
* Julian Alvarez, MD	R	222
* Julian A. Alvarez, MD	AN	222
Mercedes G. Alvarez, MD	GP	126
* Maria E. Alvarez-Krizan, MD	IM	030
Beuker F. Amann, MD	OPH	098
Adoor Amanullah, MD	PD	174
* Douglas A. Amare		222
Yazdi N. Amaria, MD	FP	198
Nitin R. Ambani, MD	U	098
Angela E. Ambrosia, MD	FP	222
* Brian A. Ameel		090
Russell K. Ameter, MD	FP	034
* Damayanti A. Amin, MD	R	174
Haresh M. Amin, MD	PD	222
Jagatbhai A. Amin, MD	IM	126
* Mohammed N. Amin, MD	PD	174
* Hassan Amirikia, MD	OBG	222
* Randall J. Amis, MD	AN	222
Chitra D. Amladi, MD	IM	222
* Mohamadali H. Amlani, MD	IM	062
* James A. Amlicke, MD	ORS	026
John S. Ammond, MD	FP	150
Claire A. Ammoun-Issa, MD	OBG	126
* Harvey E. Amoe, MD	DR	218
Norman O. Amos, MD	ORS	034
Syed A. Amouzegar, MD	IM	222
Frank L. Amprim, MD	GS	222
Gary M. Amundson, MD	R	222
* Daniel T. Anbe, MD	IM	062
Sigmund H. Ancerewicz, MD	OTO	098
Evangeline Ancheta, MD	GP	190
Henry B. Ancheta, MD	IM	190
* Louis D. Andary, MD	OBG	222
* Michael T. Andary, MD	PM	090
* Lourdes V. Andaya, MD	N	222
Roger B. Anderberg, MD	PD	218
H. Frank Andersen, MD	OBG	218
* Scott A. Anderson		222
* Barbara J. Anderson, MD	PTH	222
Beverly L. Anderson, MD	P	118
Charles P. Anderson, MD	PH	222
Christine M. Anderson, MD	FP	194
D. Hess Anderson, MD	GP	094
David G. Anderson, MD	OBG	218
* Donald T. Anderson, MD	R	054
Eugene C. Anderson, MD	U	222
Francis C. Anderson, MD	IM	050
Harley H. Anderson, MD	FP	062
Harold E. Anderson, MD	D	034
* Harry L. Anderson, MD		218
* James B. Anderson, MD	ORS	126
* Jerry W. Anderson, MD	HEM	106
* John A. Anderson, MD	PD	222
John L. Anderson, MD	R	062
* John W. Anderson, MD	R	090
* Jon C. E. Anderson, MD	AN	106
* Kent E. Anderson, MD	ORS	050
* Libby S. Anderson, MD	R	098
* Marvin D. Anderson, MD	IM	222
Mary O. Anderson, MD	FP	102
Mary Beth Anderson, DO	PTH	126
Norbert O. Anderson, MD	P	206
Norma E. Anderson, MD	PD	210
Richard T. Anderson, MD	PTH	194
* Robert E. Anderson, MD	IM	218
* Thomas F. Anderson, MD	D	218
Walter L. Anderson, MD	IM	222
* William B. Anderson, MD	OBG	222
William H. Anderson, MD	FP	082
* Lisa A. Andersson-Zetye, MD	OBG	106
* James J. Andonian, MD	OM	222
Felix O. Andrakovich, MD	P	174
Harvey M. Andre, MD	ORS	106
Larry J. Andreini, MD	FP	050
* Alice F. Andrews, MD	PD	106
Charles A. Andrews, MD	IM	106
* Kathleen M. Andries, MD	IM	026
* Marigene G. Ang		090
* Eugenius S. Ang, MD	GE	218
Daisy S. Angeles, MD	IM	222
Donna L. Angell, MD	FP	222
* Linda K. Angell, MD	OPH	090
* Michael A. Angileri, MD	DR	222
Walter M. Anglin, MD	P	102
* Elizabeth Angus, MD	N	222
* Joon N. Ann, MD	GS	222
Roger D. Annis, MD	FP	090
* M. R. Ansari, MD	GS	222
* Rudi Ansbacher, MD	OBG	218
Richard D. Anslow, MD	IM	174
* Rex D. Antinozzi, MD	IM	070
Robert C. Antle, MD	OPH	022
Shamshad Anwar, MD	PUD	194
* Zeenat Anwar, MD	OBG	194
* Ramon M. Aparece, MD	IM	126
* Peter B. App, MD	FP	106
* Robert G. App, MD	FP	190
Saul Appel, MD	D	098
William Appel, MD	A	102
* Lloyd E. Appell, MD	FP	102
Howard B. Appelman, MD	IM	222
* Mary Appelt, MD	AN	106
James E. Appelwick, MD	GS	022
* Martin I. Apple, MD	OPH	174
* Michael D. Appleford, MD	R	218
James A. Applegate, MD	FP	106
Frederick Aptowitz, MD	P	222
* Joseph N. Aquilina, MD	U	190
* Joseph W. Aquilina, MD	U	190
* Florentino A. Aquino, MD	GS	026
Adel Y. Arabbo		222
* Manaf S. Arabi, MD	N	126
* Jaime V. Aragones, MD	OPH	174
Epifania A. Aranas, MD	PD	062
* Pratap K. Aravapalli, MD	AN	062
Mohammad B. Arbabi, MD	IM	190
* Agustin Arbulu, MD	TS	222
Federico A. Arcari, MD	GS	174
* Reynaldo B. Arceno, MD	GP	222
* Thomas J. Archambeau, MD	DR	090
* Roger W. Archer, DO	FP	222
Donald H. Archibald, MD	GP	182
Eduardo Arciniegas, MD	TS	222
Amr Aref, MD	RO	222
* Miguel A. Arellano, MD	IM	126
Joseph A. Arena, MD	GS	174
Joseph A. Arends, MD	GPM	174
Norman J. Arends, MD	PS	222
* Robert C. Arends, MD	OPH	174
* John H. Arendshorst, MD	OPH	186
* Thomas R. Arendshorst, MD	OPH	186
William Arendshorst, MD	OPH	186
* Harry J. Aretakis, MD	EM	126
* Frankju A. Arevalo, MD	R	222
* S. N. Argyres, MD	IM	102
Mohammad A. Ariani, MD	OBG	222
Constantine T. Aries, MD	DIA	222
* Severo R. Armada, MD	AN	222
Robert M. Armbruster, MD	R	062
* Anna A. Armedilla		090
* Herminio A. Armovit, MD	IM	114
John W. Armstead, MD	OBG	222
* Rhonda M. Armstrong		222
* John R. Armstrong, MD	IM	090
Mac J. Armstrong, MD	PH	222
* Richard A. Armstrong, MD	GS	066
George C. Arnas, MD	U	190
Wallace A. Arneson, MD	GS	218
* Marc S. Arnkoff, MD	U	174
Morris J. Arnkoff, MD	U	222
* Constance G. Arnold, MD	PS	134
* Daniel J. Arnold, MD	IM	134
Janet S. Arnold, MD	FP	126
William J. Arnold, MD	FP	222
A. Robert Arnstein, MD	IM	174
* Stephen J. Arntz		222
* Regine Aronow, MD	PD	222
* Peter J. Aronson, MD	D	174
Stig E. Aronsson, MD	IM	174
* Dexter E. Arrington, MD		222
* Harold M. Arrington, MD	OBG	222
* Robyn J. Arrington, MD	OBG	222
* Maria S. Arrubla, MD	P	222
Abdul G. Arshad, MD	GS	114
* Charles G. Artinian, MD	IM	174
Leslie H. Arwin, MD	FP	218
Richard B. Asbury, MD	GS	114
* George F. Ascherl, MD	DR	022
* Stephen M. Ascherl, MD	DR	022
* Ingida Asfaw, MD	GS	222
* Richard J. Ashack, MD	D	106
Raymond J. Ashare, MD	GS	174
* Andrew W. Asimos, MD	EM	222
* Ralph F. Askam, MD	AN	162
James C. Askins, MD	FP	098
Dean R. Asselin, MD	P	026
* Zacarias G. Asuncion, MD	TS	222
* Elaine L. Atallah, MD	IM	222
* Pierre C. Atallah, MD	IM	174
Steve Atallah, MD	IM	222
Russell M. Atchison, MD	FP	218
Avery J. Aten, MD	FP	014
Richard B. Atkins, MD	P	174
Annie L. Atkinson, MD	GP	162
David E. Atkinson, MD	FP	054
Herbert A. Atkinson, MD	FP	026
James E. Atkinson, MD	FP	018
* Mark B. Atkinson, MD	AN	102
* Haralambos Atoynatan, MD	IM	206

Alphabetical Listing of MSMS Members

** Asterisk beside name denotes AMA membership*

* Manohar L. Atri, MD	N	190
Akbar Attary, MD	IM	158
Antony K. Attie, MD	U	222
John B. Atwater, MD	PH	218
* Blaise U. Audet, MD	NS	174
Thomas C. Auer, MD	IM	070
* Kimberly B. Augenstein		218
Harry E. August, MD	PYA	222
Robert W. Augustine, MD	ORS	222
* Gary T. Augustyn, MD	DR	218
Phillip F. Augustyn, MD	OPH	218
* Colleen R. Aujero, MD	PD	222
Hal G. Aulie, MD	GS	174
Robert G. Ause, MD	R	218
* Domenico S. Ausiello, MD	FP	094
* Eric D. Austad, MD	PS	218
Barry I. Auster, MD	D	174
* Miles S. Auster, MD	IM	174
* Alfred C. Austin, MD	OBG	222
* David K. Austin, MD	AN	074
* Donald C. Austin, MD	NS	222
* Edward Austin, MD	GS	190
Eugene S. Austin, MD	IM	206
* Mark B. Austin, MD	PTH	102
* Robert J. Austin, MD	OBG	102
Shirley Austin, MD	AN	222
John D. Ausum, MD	D	222
Mohsen M. Avaregan, MD	PD	174
Mustafa Avci, MD	GP	174
* Fred Averbuch, MD	OTO	126
Walter C. Averill, MD	FP	190
Noyes L. Avery, MD	IM	106
* Muzaffar K. Awan, MD	GP	222
* Gavin I. Awerbuch, MD	N	022
Arnold R. Axelrod, MD	IM	222
* David Axelrod, MD	IM	174
* Eugene H. Axelrod, MD	AN	218
Mildred A. Axelrod, MD	IM	174
John A. Axelson, MD	IM	098
* Jose R. Ayala, MD	PD	034
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* Charles E. Boonstra, MD	PTH	026
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* Richard S. Boss, MD	FP	166
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* Sidney F. Bottoms, MD	OBG	222
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* Robert E. Brantley, MD	R	090
* Daniel W. Brash, MD	NEP	026
Zane A. Brashares, MD	GP	098
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* Robert K. Brateman, MD	FP	174
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* Walter M. Braunohler, MD	ORS	106
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* Caridad B. Bravo-Fernandez, MD	AN	222
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Rebecca S. Brienza		090
Joy D. Briggs		090
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* Rafael C. Brillantes, MD	IM	098
J. Russell Brink, MD	IM	106
* Thomas W. Brink, MD	IM	106
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* Bruce B. Brintnall, MD	IM	106
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* Anna H. Broecker, MD	PTH	090
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Margaret J. Byers, DO	OBG	090
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* Lawrence C. Cairns, MD	OBG	026
* Tomas R. Cajigas, MD	PTH	022
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* B. Douglas Campbell, MD	N	034
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* Frank C. Campbell, MD	R	106
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* John S. Campbell, MD	ORS	022
* Lawrence F. Campbell, MD	R	222
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* Peter B. Campbell, MD	IM	062
Richard E. Campbell, MD	GS	094
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Robert E. Campbell, MD	IM	222
* Ruth B. Campbell, MD	GS	222
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* Lucy R. Canaday, MD	FP	218
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* Patrick J. Canning, MD	OBG	090
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* Robert T. Carlson		090
Ralph E. Carlson, MD	GS	054
* Ralph G. Carlson, MD	FP	090
* Rodney F. Carlson, MD	IM	102
* Vernette M. Carlson, MD	FP	146
Waldo B. Carlson, MD	IM	054
Jack H. Carman, MD	IM	218
Kenneth W. Carman, MD	FP	222
Padraic C. Carmody, MD	GS	102
* Peter E. Carmody, MD	FP	082
* James C. Carney, MD	IM	174
* Jeffery W. Carney, MD	IM	190
John R. Carney, MD	FP	138
Ruth V. C. Carney, MD	FP	138
* Christopher R. Carpenter		222
* Ernest W. Carpenter, MD	GS	170
* Glenn B. Carpenter, MD	ORS	174
* James E. Carpenter, MD	ORS	218
* Kathleen E. Carpenter, MD	R	070
* Richard L. Carpenter, MD	OTO	090
William S. Carpenter, MD	GS	222
* Jack N. Carr, MD	P	106
Lee Carrick, MD	D	222
* Antonio P. Carrillo, MD	CD	102
* Jose A. Carrion, MD	DR	194
Catherine J. Carroll, MD	PD	218
* I. Dale Carroll, MD	OBG	166
Jerome G. Carroll, MD	IM	222
* David L. Carter, MD	R	086
* James W. Carter, MD	IM	102
James A. U. Carter, MD	IM	222
* John H. Carter, MD	IM	026
Norman A. Carter, MD	PD	062
Samuel H. Carter, MD	AN	218
* William C. Cartmill, MD	PD	102
* Henry A. Cartwright, MD	U	222
* William H. Cartwright, MD	OPH	070
* George A. Carty, MD	GS	190
Joseph A. Caruso, MD	OBG	090
* Coye T. Carver, MD	OPH	222
Zeia Casab, MD	IM	222
* Philip N. Cascade, MD	R	222
Gregory D. Casey, MD	GS	098
* John F. Casey, MD	IM	222
Denis F. Cash, MD	OM	222
Morton B. Cash, MD	R	222
* Ralph Cash, MD	PD	222
Gaston L. Casillas, MD	GS	102
Eldon E. Cassell, MD	PTH	018
* Bader J. Cassin, MD	PTH	222
* Nicanor F. Castedo, MD	P	174
Cesar P. Casten, MD	GP	095
* H. H. Castilla-Ortiz, MD	PTH	082
* Franklin H. Castillo, MD	OBG	222
Jane I. Castillo, MD	OBG	190
* Reynaldo G. Castillo, MD	NS	106
* Maurice E. Castle, MD	ORS	222
Douglas H. Castleman, MD	AN	018
* Lawrence D. Castleman, MD	OPH	222
Joseph V. Catalano, MD	R	222
* Albert C. Cattell, MD	D	218
* James A. Catto, MD	GS	174
* Allan D. Caudill, MD	VS	034
Edgar H. Caughey, MD	GP	222
Hugh T. Caumartin, MD	R	190
* David W. Cavanagh, MD	IM	102
Filiberto Cavazos, MD	PTH	222
* George D. Cavender, MD	PM	162
* John W. Cavendish, MD	FP	190
L. Harold Caviness, MD	P	034
William Cayce, MD	IM	106
* Jana S. Cazers, MD	D	102
* Daniel J. Cecconi, MD	GS	054
* Richard D. Cecconi, MD	GS	054
Richard D. Cecconi, MD	GP	054
* Frank T. Celis, MD	PS	098
Robert M. Centeno		218
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* Albert J. Ceravolo, MD	AN	222
* Joseph C. Cerny, MD	U	218
* Gabriel Ceron, MD	DR	082
* John T. Cerovski, MD	IM	102
Eugene J. Cetnar, MD	EM	222
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Henry Cevallos, MD	N	162
Ahmed Chaballout, MD	GS	222
* Elsamma Chacko, MD	IM	102
Mohinder S. Chadha, MD	CLP	114
John M. Chadwick, MD	D	034
Mansuk Chae, MD	OBG	222
* Song H. Chae, MD	PTH	222
* William M. Chae, MD	R	222
Dan M. Chaffee, MD	EM	186
Mahmoud Chafty, MD	AN	194
* Michael D. Chafty, MD	AN	106
T. Chairatana, MD	AN	222
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B. P. Chakraverty, MD	ORS	062
Vijay K. Chaku, MD	IM	190
N. Venkata Chalam, MD	CD	222
* Ned I. Chalat, MD	OTO	222
* Ricardo Chalela, MD	R	126
Ray W. Chamberlain, MD	ABS	096
* George M. Chamberlin, MD	PM	034
Wayne A. Chambers, MD	AN	222
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* David W. Chamness, MD	PD	186
* James K. Chamness, MD	PD	186
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* C. Kohler Champion, MD	IM	174
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Alexander U. Chan, MD	IM	062
* Francisco N. Chan, MD	U	222
Lawrence S. Chan, MD	D	222
Paul L. Chan, MD	GS	022
Paulino S. Chan, MD	IM	034
* Raymond K. Chan, MD	NPM	062
Donald Chandler, MD	GP	106
Edward M. Chandler, MD	GS	034
Joseph H. Chandler, MD	N	174
* William F. Chandler, MD	NS	218
Naveen Chandra		218
* Amnat Chandra, MD	OBG	126
* Sharath S. Chandra, MD	IM	222
* Boonchoo Chang, MD	IM	038
Byung H. Chang, MD	DR	062
* Cheng-Yang Chang, MD	U	062
* Chul Chang, MD	IM	214
* Emily M. Chang, MD	GP	126
Hang S. Chang, MD	R	222
* Hyun S. Chang, MD	GS	222
* Jung H. Chang, MD	R	222
Nora F. Chang, MD	PD	226
* Suk J. Chang, MD	AN	090
Mariann M. Channell, MD	OPH	126
* Satya B. Chaparala, MD	IM	034
* Johanna Chapel, MD	D	222
* Thomas A. Chapel, MD	D	222
Lydia A. Chapelsky, MD	PD	218
* Harvey N. Chapin, MD	P	170
* Maurice H. Chapin, MD	FP	210
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Janet L. Chapman, MD	IM	174
Roland H. Chapman, MD	P	222
* Eugene J. Chapp, MD	PD	174
Barbara M. Chapper, MD	PD	222
Christopher C. Chaput, MD	AN	174
* Harold P. Charbeneau, MD	PD	126
* Del C. Charbonier, MD	IM	126
* Luis M. Charbonier, MD	IM	126
* Eugene N. Chardoul, MD	IM	062
* Veena B. Chari, MD	OBG	222
* C. Robert Charles, MD	D	170
Martin L. Charles, MD	IM	222
* Arnold D. Charnley, MD	ORS	222
* Catherine A. Chartier, MD	OBG	174
* Kathleen E. Chase, MD	AN	106
* R. Jack Chase, MD	IM	106
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Walter E. Chase, MD	GS	010
Jacob L. Chason, MD	PTH	222
* George J. Chatas, MD	AN	218
* John W. Chatas, MD	AN	218
Pranab Chattopadhyay, MD	IM	106
* Pyra S. Chauhan, MD	U	222
Jeffrey K. Chaulk, MD	OPH	150
James B. Chauncey, MD	IM	098
Kathleen M. Chauvin, MD	FP	034
* Manuel R. Chavarri, MD	IM	014
Russell C. Chavey, MD	FP	222
Cleofe J. Chavez, MD	PD	134
* William M. Chavis, MD	OBG	222
* Avinash C. Chawla, MD	PD	174
Prayad Chayapruks, MD	IM	134
* Tony P. Chebli, MD	FP	090
* Frank E. Check, MD	IM	222
* Pavitar S. Cheema, MD	P	174
Lynn Chen		218
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* Chihsing C. Chen, MD	GS	034
Chin-Shuh C. Chen, MD	OBG	222
* David W. T. Chen, MD	CD	190
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* Bradley J. Cherenzia, MD	R	222
* Allan W. Chernick, MD	CD	222
* John F. Cherry, MD	DR	190
* Radha Cherukuri, MD	OBG	190
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* William D. Cheslin, MD	HNS	174
Joseph L. Chess, MD	ORS	102
* Vicki E. Chessin, MD	FP	074
Alice S. Chester, MD	P	222
* Silas C. Cheuk, MD	FP	222
Ramesh L. Chheda, MD	PD	062
David Chi		218
* Seong H. Chi, MD	TS	090
Young H. Chi, MD	AN	090
* Young H. Chi, MD	AN	126
* Louis C. Chiara, MD	D	222
* Antonio M. Chiasson, MD	AN	162
* Elie J. Chidiac, MD	AN	222
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* Petra S. Ching, MD	OBG	222
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* Adolfo M. Chipoco, MD	FP	222
Ronald S. Chipps, MD	IM	102
Baby Chirumamilla, MD	P	222
* Neldagae S. Chisa, MD	D	174
Peter R. Chisena, MD	FP	190
* Michael A. Chita, DO	R	222
Darapen Chivalak, MD	OBG	222
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* Kwang S. Cho, MD	FP	034
* Kyn Hong Cho, MD	AN	222
Bernard Chodorkoff, MD	P	174
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* Gary Chodoroff, MD	PM	222
Dale D. J. Chodos, MD	PA	102
Don S. Choe, MD	AN	026
Byong-Du Choi, MD	AN	090
* Chang S. Choi, MD	PS	174
* Joon Young Choi, MD	P	222
* Kong C. Choi, MD	GS	062
Sang H. Choi, MD	GS	174
* Soon A. Choi, MD	IM	062
* Yung S. Choi, MD	AN	026
* Kalpana A. Choksi, MD	PD	222
Nishit A. Choksi, MD	CD	174
* Chairat Chomchai, MD	CRS	222
* Wook-Chin Chong, MD	DR	126
Hari G. Chopra, MD	NS	174
Elaine G. Chottiner, MD	IM	218
* Abdul S. Choudhry, MD	IM	222
* Sajal P. Choudhury, MD	PTH	222
* Cynthia T. Chow, MD	D	174
* Jim Y. Chow, MD	GS	086
* Marion C. Chown, MD	EM	222
Clarence P. Chrest, MD	R	102
* David J. Christ, MD	ORS	102
* Carl W. Christensen, MD	OBG	222
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* R. C. Christensen, MD	CD	222
Randall M. Christenson, MD	P	106
* Daniel K. Christian, MD	IM	102
James L. Christiansen, MD	PD	134
* Lance M. Christiansen, MD	OBG	174
* T. W. Christiansen, MD	TS	026
* Adrian J. Christie, MD	PTH	222
* Wallace C. Christy, MD	IM	218
Hung-Ming Chu, MD	P	062
* Randy M. Chudler, MD	U	126
* Su-Jin Chung, MD	P	222
* Tae-Hong Chung, MD	FP	194
William J. Chung, MD	PD	174
Woon-Man Chung, MD	DR	090
* Yong S. Chung, MD	AN	062
Annamaria T. Church, MD	PD	174
* William R. Church, MD	DR	070
John H. Cieszkowski, MD	IM	174
S G. Cilella, MD	PTH	026
* John M. Cilluffo, MD	NS	070
Mark W. Cimmerer, MD	R	090
* Barbara J. Cingel	IM	222
* Mary C. Ciotti, MD	OBG	090
Christine M. Cisneros, MD	OM	222
* Jerome V. Ciullo, MD	ORS	174
* Yolaine A. Civil		222
Eugene F. Claeys, MD	FP	218
* Allan G. Clague, MD	N	218
* Erwin G. Clahassey, MD	OPH	106
* Paul E. Clancy, MD	TS	222
* Sandra K. Clapp, MD	PD	222
Muir Clapper, MD	IM	222
John R. Clara, MD	R	086
Arthur M. Clark, MD	GP	222
* Gaius D. Clark, MD	EM	090
Jack L. Clark, MD	OTO	222
James F. Clark, MD	ATP	130
* Jeffrey K. Clark, MD	AN	222
John M. Clark, MD	R	204
* Mark D. Clark, MD	AN	102
Mark S. Clark, MD	FP	062
Max D. Clark, MD	R	174
* Michael R. Clark, MD	EM	090
* Oswald V. Clark, MD	ORS	070
Randall Clark, MD	FP	106
Ray H. Clark, MD	HEM	098
* Robert L. Clark, MD	PD	062
Robert L. Clark, MD	PTH	026
Robert T. Clark, MD	OPH	118
William P. Clark, MD	GP	222
David J. Clarke, MD	OBG	222
Harriet A. Clarke, MD	AN	174
Norman E. Clarke, MD	IM	222
Robert B. Clarke, MD	P	222
John M. Clarkson, MD	GP	046
Susan T. Clarkson, MD	GP	046
April A. Clause		222
Carroll K. Clawson, MD	IM	106
* Michael A. Clay		090
* Edward A. Clay, MD	IM	222
* Joel W. Clay, MD	GS	126
* William E. Clay, MD	AN	126
* Lewis Clayman, MD	HNS	222
Bevin T. Clayton, DO	EM	014
* Robert K. Cleary, MD	GS	218
William K. Clegg, MD	EM	102
Robert H. Cleland, MD	GS	050
* William D. Cleland, MD	PD	194
Frederick L. Clement, MD	GS	102
* Volna Clermont, MD	PD	222
Parish B. Cleveland, MD	AN	222
J. Daniel Clifford, MD	A	098
Robert P. Clifford, MD	GS	194
* Robert W. Clifford, MD	OTO	206
Andrew R. Climie, MD	PTH	222
Alan L. Cline, MD	PD	174
* Robert G. Cline, MD	AN	070
Theodore N. Cline, MD	GS	070
Warren W. Cline, MD	CD	070
* William S. Cline, MD	IM	154
George R. Clinton, MD	GP	090
James E. Clinton, DO	IM	222
* Richard K. Clise, MD	FP	106
* R. Paul Clodfelder, MD	IM	106
* M. Gerard Cloherty, MD	PTH	106
* Deborah L. Cloney, MD	PD	106
James S. Close, MD	OPH	090
* Robert C. Clouse, MD	FP	166
Robert A. Clowater, MD	PUD	190
Veldora F. Clunas, MD	IM	174
Ensign E. Clyde, MD	FP	218
* L. Mason M. Cobb, MD	PS	090
Thomas H. Cobb, MD	IM	174
* Ronald M. Coburn, MD	OPH	222
Edgar G. Cochrane, MD	GP	222
* Ellen M. Coggeshall, MD	OBG	106
* Steven P. Cogswell	FP	090
* Bruce E. Cohan, MD	OPH	218
* Alan D. Cohen, MD	D	126
Alberto Cohen, MD	CD	126
Carl J. Cohen, MD	D	174
* Cynthia C. Cohen, MD	FP	222
* Daniel H. Cohen, MD	OBG	174
* Della D. Cohen, MD	GYN	174
Lewis Cohen, MD	PM	174
* Melvin F. Cohen, MD	P	174
* Sanford N. Cohen, MD	PD	222
* Seth D. Cohen, MD	OTO	174
* Steven R. Cohen, MD	GS	218
* Stephen D. Cohle, MD	PTH	106
Arnold M. Cohn, MD	OTO	222
Edward M. Cohn, MD	OPH	174
S. Leonard Cohn, MD	OBG	174
Sorab A. Colah, MD	NS	126
* Celal Colak, MD	IM	174
* Douglas L. Colberg, MD	FP	198
* Gail M. Colby		222
Gerald G. Cole, MD	OTO	062
* Larry M. Cole, DO	AN	022
Versa V. Cole, MD	GP	170
Neil C. Colegrove, MD	FP	106
* James D. Coleman, MD	EM	222
John F. Coleman, MD	AN	070
* Richard G. Coleman, MD	EM	186
Susan E. Coleman, MD	IM	174
Douglas J. Coles, MD	FP	070
Peter G. Coles, MD	PD	102
Thomas B. Coles, MD	OS	222
* Harry T. Colfer, MD	CD	170
* Alonso Collar, MD	TS	090
James R. Collet, MD	OM	154
* Beverly A. Collier, MD	AN	090
* Richard L. Collier, MD	GS	090
* Paul C. Colligan, MD	CLP	190
Edward F. Collins, MD	FP	174
Hubert V. Collins, MD	AN	034
James U. Collins, MD	AN	106
* Jay D. Collins, MD	GS	150
* John J. Collins, MD	FP	106
* John T. Collins, MD	GS	102
* Lois B. Collins, MD	FP	102
* Thomas D. Collins, MD	FP	010
Vicki H. Collins, MD	FP	174
* Kathy L. Collins-Williams, MD	OBG	106
* David J. Collon, MD	ORS	222
* Pino D. Colone	EM	090
* Lee H. Colony, MD	PS	090
Diane F. Colquhoun, MD	IM	034
Graham F. Colquhoun, MD	OPH	034
Peter J. Colquhoun, MD	OPH	034
* Jeffrey J. Colton, MD	OTO	174
* John C. Colwill, MD	ORS	106
* William B. Comai, MD	ORS	034
Julius V. Combs, MD	OBG	222
* Robert G. Combs, MD	GS	090
Jacqueline R. Compton, MD	OBG	174
Barton L. Comstock, MD	PD	026
* Howard C. Comstock, MD	PD	090
* Howard M. Comstock, MD	GS	158
Lawrence A. Comstock, MD	FP	222
Charles E. Conaway, MD	GP	110
* Donald P. Condit, MD	ORS	106
Michelle M. Condon, MD	IM	106
* Gina M. Conflitti, MD	IM	222
* David E. Congdon, MD	PTH	062
* Douglas D. Congdon, DO	PTH	062
* Emma J. Conklin, MD	IM	222
* Michael K. Conley, MD	OBG	134
William R. Conley, MD	FP	222
Jerome W. Conn, MD	END	218
P. J. Connaughton, MD	GS	170
Edward D. Conner, MD	AN	114
Brian A. Connolly, MD	P	174
Paul J. Connolly, MD	GS	222
Thomas Connolly, DO	OBG	222
* Robert H. Connors, MD	PDS	106
Alan J. Conrad, MD	FP	226
* Jerome A. Conrad, MD	ORS	142
Maynard M. Conrad, MD	ORS	102
* Mary E. Conroy, MD	ORS	222
Dion S. Consengco, MD	IM	098
Elizabeth G. Consengco, MD	OBG	098
* Basil B. Considine, MD	RO	126
* Louis L. Constan, MD	FP	190
* Diana M. Constance, MD	P	174
* Errikos L. Constant, MD	PS	090
Aeneas Constantine, MD	GP	014
Abelardo G. Contreras, MD	N	174
* Gerald F. Conway, MD	U	174
* William A. Conway, MD	IM	222
William S. Conway, MD	OPH	170
Brian W. Cook, MD	EM	218
Carla A. Cook, MD	TR	174
Carlton L. Cook, MD	GP	114
* David A. Cook, MD	ON	022
Frank W. Cook, MD	GS	062
J. Maxwell Cook, MD	PH	090
James C. Cook, MD	R	222
* John M. Cook, MD	OBG	054
* Ralph R. Cook, MD	OM	154
Robin D. Cook, MD	EM	106
Thomas J. Cook, MD	FP	014

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* David L. Cooke, MD	OPH	026
* Cory E. Cookingham, MD	PDA	062
* Cynthia L. Cookingham, MD	PD	174
Franklin T. Cookinham, MD	AN	222
Norton J. Cooksey, MD	IM	070
* John R. Cooley, MD	OBG	102
Roy V. Cooley, MD	FP	174
* Joseph M. Cools, MD	P	134
* Robert J. Coombs, DO	AN	014
* Norman E. Coon, MD	CLP	106
* Janelle L. Cooper, MD	N	218
Joseph E. Cooper, MD	FP	214
Paul F. Cooper, MD	GS	102
Ralph R. Cooper, MD	IM	222
* Raymond Cooper, MD	OBG	162
Richard F. Cooper, MD	R	218
* Robert S. Cooper, MD	PD	174
Suzanne S. Cooper, MD	PD	098
* Theodore Cooper, MD	GS	102
* John W. Copenhaver, MD	DR	102
* Elizabeth A. Copland, MD	DR	218
* James W. Copping, MD	GS	194
* Arnold G. Coran, MD	PDS	218
* David P. Corbett, MD	R	222
John V. Corbett, MD	ORS	126
* Thomas H. Corbett, MD	AN	218
* Jerome F. Cordes, MD	IM	090
* Jerome F. Cordes, MD	DR	090
* Roberto B. Cordoba, MD	RO	190
* Louis B. Coriasso, MD	FP	062
Goldie Corneliuson, MD	PH	090
* Karen A. Cornell, MD	PD	162
* Diane S. Cornellier, MD	N	070
* Frank L. Cornish, MD	P	102
* Maria Corondan, MD	GP	126
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William A. Corsini, MD	GS	086
Benedicto C. Cortez, MD	IM	222
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* Stephen D. Costello, MD	FP	222
* John F. Cotant, MD	CD	174
John F. Cotant, MD	GS	222
* Michael G. Cotant, MD	GS	174
Moises G. Coto, MD	IM	222
David B. Cotton, MD	OBG	222
Edward Cotton, MD	FP	214
* Nancy Couch, MD	IM	222
* James I. Coughlin, MD	IM	174
* Eric W. Coulter		090
Robert W. Counts, MD	R	174
Wayne Court, MD	RO	222
* Susan Courtnage, MD	IM	058
James T. Courtney, MD	GS	174
* N. Warn Courtney, MD	R	102
Jayne E. Courts, MD	IM	106
Gary C. Courville, MD	IM	190
John J. Coury, MD	GS	194
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* Wayne M. Couwenhoven, MD	IM	106
Vivina C. Covacha-Rosal, MD	OPH	174
* Richard M. Cover, MD	R	070
John S. Cowan, MD	IM	174
* Jon P. Cowan, MD	AN	106
* Mark D. Cowan, MD	IM	134
* William D. Cowan, MD	AN	162
* John W. Cowden, MD	OPH	222
Robert L. Cowen, MD	U	222
Clarissa C. Cowles, MD	OBG	174
Clifford J. Cox, MD	OPH	062
* Edward O. Cox, MD	PD	106
* Morton S. Cox, MD	OPH	218
William L. Cox, MD	ORS	222
Robert D. Coye, MD	PTH	222
* J. Michael Coyne, MD	PM	134
David R. Cragg, MD	CD	174
* Brian M. Craig, MD	DR	222
* Charles P. Craig, MD	ID	218
Curtis P. Craig, MD	FP	126
* Jean A. Craig, MD	OBG	106
Marvin D. Craig, MD	OBG	158
Alan R. Crain, MD	ORS	222
* Ralph A. Cram, MD	FP	034
* Philip G. Cramer, MD	PUD	222
Donald K. Crandall, MD	GS	162
Linda L. Crandall, MD	PD	126
* Jeffrey C. Crandle, DO	FP	162
Keith H. Crane, MD	IM	106
* Steven A. Crane, MD	IM	106
Guy A. Crawford, MD	FP	098
* John W. Crawford, MD	GS	162
* Michael J. Crawford, MD	GP	106
Eugene H. Crawley, MD	PD	222
Kenneth R. Crawley, MD	GP	102
Austin G. Craymer, MD	GP	138
Ray O. Creager, MD	OPH	102
John A. Cremer, MD	GS	106
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Frank C. Cretsinger, MD	GS	102
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* Harold P. Crissinger, MD	FP	146
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* John D. Crissman, MD	ATP	222
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Nelu Cristof, MD	OBG	222
* Raymond E. Croasdale, MD	OPH	102
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* Paul D. Croissant, MD	NS	174
Maurice M. Croll, MD	OPH	222
Anne B. Cronick, MD	P	162
* Robert L. Cross, MD	GS	062
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Robert J. Crossen, MD	OPH	218
* Kevin Crosslin, MD		222
* Eduardo R. Crotte, MD	DR	102
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Maria A. Crumes, MD	R	222
* Leon A. Crumley, MD	IM	222
* Victor M. Cruz, MD	P	222
Maria V. Cserhalmi, MD	GP	222
* Nicholas Csonka, MD	AN	022
* Sergio Q. Cuison, MD	AN	162
* Walter S. Cukrowski, MD	OPH	174
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J. Douglas Gay, MD	PTH	170
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Millard R. Golusin, MD	OBG	174
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* Fernando C. Gomez, MD	PTH	186
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Silvia T. Gomez-Seoane, MD	IM	062
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* Robin I. Goodfellow, MD	GS	030
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* Gary R. Goodman, MD	CDS	222
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Edmond J. Gostine, MD	FP	222
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Ramsewak Goswami, MD	FP	222
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* Abraham G. Gotman, MD	OBG	222
* Narsimha R. Gottam, MD	CD	222
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* Sadananda C. Goud, MD	OBG	102
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Gertrude B. Gregory, MD	OM	126
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Paul G. Gruca, MD	FP	074
* James C. Gruenberg, MD	GS	190
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Lynn M. Grund		090
* Alan B. Gruskin, MD	PD	222
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* Bernard C. Grysen, MD	EM	090
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* Rao V. C. Gudipati, MD	IM	190
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* Hernan L. Guiang, MD	IM	162
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James A. Guigelaar, MD	IM	022
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Peregrino A. Guillen, MD	AN	194
* Mounir F. Guindi, MD	GS	222
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Ramabrahman Gullapalli, MD	AN	174
* Edwin H. Gullekson, MD	FP	062
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Charles R. Gumpper, MD	FP	062
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* Thomas P. Gushurst, MD	GE	102

Gushurst

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Paul A. Haupt, DO	GP	146
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* Thomas J. Haverbush, MD	ORS	074
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Extra strength pain relief you can phone in.

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[2] Standard industry new prescription audit.
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Vicodin ES®

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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain. **CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone. **WARNINGS: Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression. **Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS: Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy: Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE: Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992 5890

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* Marjorie J. Hickman, MD	IM	034
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* Thomas F. Higby, MD	EM	118
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* Cecelia F. Hissong, MD	FP	222
* Bohdan Hnatiuk, MD	OBG	222
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* James Hood, MD	IM	154
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* Andrew J. Hopkins, MD	FP	222
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* Benjamin G. Horn		090
* Sherman W. Horn, MD	EM	058
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* David J. Horning, MD	U	106
* Andrij W. Horodysky, MD	FP	126
Orest E. Horodysky, MD	IM	222
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* Brian L. Hotchkiss, MD	ORS	106
* Linda S. Hotchkiss, MD	P	222
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* J Christopher Hough, MD	FP	154
* Joseph H. Hough, MD	FP	096
Joseph A. Houle, MD	PTH	014
* Michael R. Hourani, MD	IM	090
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* Susan W. Howard, MD	FP	014
Susan W. Howard, MD	FP	062
Willard H. Howard, MD	GP	102
* William A. Howard, MD	IM	070
* William K. Howard, MD	PD	222
Donnell C. Howe, MD	GS	042
* Lynn E. Howell, MD	CDS	174
Richard H. Howell, MD	FP	154
* Terry D. Howell, MD	IM	150
* Timothy G. Howell, MD	AN	106
Genevieve G. Howen, MD	PH	090
Homer A. Howes, MD	AI	222
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John A. Howland, MD	IM	022
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* Chris R. Howlett, MD	P	174
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* Linda L. Hryhorczuk, MD	CHP	222
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* William C. Humphrey, MD	FP	134
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Yuh-Lin Hung, MD	PD	086
Maurice E. Hunt, MD	FP	022
Richard J. Hunt, MD	OM	062
Robert Hunter		222
* Alan F. Hunter, MD	TS	134
* Laura J. Hunter, DO	FP	126
Marilyn R. Hunter, MD	PD	106
* Robert B. Hunter, MD	IM	222
* Valerie P. Hunter, DO	OBG	098
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* John B. Huntington, MD	ORS	034
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Lenny J. Hutton, MD	OBG	174
Gene L. Hwang, MD	IM	026
* Kyu J. Hwang, MD	OBG	194
* Soo Y. Hwang, MD	AN	062
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* Anne-Mare Ice, MD	PD	222
* Melonie S. Ice, MD	IM	106
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Chaudhary M. Idress, MD	IM	114
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* Michael S. Jakubowski, MD	PM	106
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* Hildegard T. Jamerson, MD	PD	070
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* V. Jayabalan, MD	NM	062
Saroja S. Jayakar, MD	IM	222
Jamboor E. Jayashanka, MD	IM	222
* Tikee C. Jayasvasti		090
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* Loyal W. Jodar, MD	ORS	170
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Kyung H. Joe, MD	IM	222
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* Geetha V. John, MD	PD	222
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* Arthur J. Johnson, MD	U	222
* Calvin Johnson, MD	OBS	222
* Carolyn E. Johnson, MD	PD	222
Charles C. Johnson, DO	FP	150
David B. Johnson, MD	U	090
* David K. Johnson, MD	U	090
* Donald F. Johnson, MD	PD	102
* Douglas A. Johnson, MD	GS	166
* Edward N. Johnson, MD	FP	042
Frank D. Johnson, MD	OPH	096
Gage Johnson, MD	OBG	222
* Garfield Johnson, MD	OBG	174
* Gary A. Johnson, MD	OPH	190
* Gary K. Johnson, MD	PD	062
* Gregory W. Johnson, MD	GS	106
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J. Frederic Johnson, MD	GP	174
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* James M. Johnson, MD	EM	150
* James W. Johnson, MD	CHP	174
Jeffrey R. Johnson, MD	GS	090
Jo Ann Johnson, DO	FP	062
* Joel A. Johnson, MD	CD	134
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* Georg H. Klutke, MD	OBG	222
* Cassandra M. Klyman, MD	PYA	174
* David C. Kmak, MD	OBG	222
James G. Knaggs, MD	OPH	062
* James E. Knake, MD	DR	218
Morgan A. Knapp		222
* Gary H. Knapp, MD	GP	222
John A. Knapp, MD	OBG	222
William L. Knapp, MD	OM	222
* William T. Knapp, MD	R	190
Richard A. Knecht, MD	FP	170
* Sharon K. Knepfler, MD	PD	222
Melodie A. Knicely, MD	FP	062
* Donald E. Knickerbocker, MD	PD	090
* Edwin M. Knights, MD	PTH	174
Howard T. Knobloch, MD	PD	022
Frederick J. Knocke, MD	ORS	222
Bruce F. Knoll, MD	U	098
Stuart A. Knott, MD	OPH	222
Pamela R. Knysz, MD	FP	106
* Michael S. Kobernick, MD	EM	174
Sidney D. Kobernick, MD	PTH	222
* Robert P. Kobiela, MD	IM	106
* Josef M. Kobiljak, MD	PD	222
Stefan H. Kobiljak, MD	OBG	222
Robert J. Kobs, MD	OPH	098
Karen S. Koby Olson, MD	PD	150
Krystyna Kochanowska, MD	IM	222
Eugene J. Kochkodan, MD	R	222

Alphabetical Listing of MSMS Members

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Lubomira S. Kocur, MD	GP	110
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Jill E. Koehler, MD	PD	062
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* Earl R. Koenig, MD	U	126
Harry Koenig, MD	OPH	134
George H. Koepke, MD	PM	190
* Kurt J. Koepnick, MD	IM	106
Edward J. Koerber, MD	GP	222
John M. Koetsier, MD	PD	106
* Marvin L. Kofender, MD	IM	222
Alan O. Kogan, MD	P	102
Natalio Kogan, MD	AN	222
A. L. Koh-Guevarra, MD	IM	126
* William M. Kohen, MD	ORS	174
* James Kohlenberg, MD	IM	174
* Darrell J. Kohli, MD	OPH	050
* Jaspal S. Kohli, MD	EM	222
Gloria J. Kohut, MD	PTH	106
Dinesh P. Koirala, MD	AN	222
* Ray S. Koivunen, MD	FP	054
* Evan P. Kokales, MD	OM	102
* Mary J. Kokosky, MD	NPM	222
Karl F. Kolbe, MD	IM	174
* James A. Kolberg, MD	GS	070
* Bruce H. Kole, MD	N	174
* Linda J. Kole, MD	IM	174
* Augustine K. Kole-James, MD	IM	222
Robert C. Kolesar, MD	GP	154
* Mark D. Kolins, MD	CLP	222
Miroslav Kollar, MD	GP	126
Isadore I. Kolman, MD	U	222
* Gary F. Koloff, MD	P	158
* Oscar P. Koltay, MD	R	095
* Lawrence Koltonow, MD	P	174
A. Prasad Kommareddi, MD	IM	062
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Harvey J. Komorn, MD	GS	174
* Raymond R. Komray, MD	OTO	162
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* Bobby K. Kong, MD	TS	218
* John W. Konnak, MD	U	218
* Edward T. Konno, MD	PTH	222
* Dennis W. Konzen, MD	FP	102
Chester S. Koop, MD	IM	070
* John H. Kopchick, MD	U	106
* Joseph Kopchick, MD	GP	094
Joseph M. Kopmeyer, MD	IM	222
* Clemens M. Kopp, MD	CLP	194
* Carolyn Koppenol, MD	P	014
Peter C. Koptik, MD	EM	106
Andrew Kopystynsky, MD	GS	222
* Theresa A. Kordish, MD	FP	102
Michael A. Kore, MD	PD	102
Louis Koren, MD	P	222
* Bert J. Korhonen, MD	ORS	106
Ronald W. Kornak, MD	OTO	098
* Jeffrey A. Kornblum, MD	NS	102
* James G. Kornmesser, MD	OBG	174
Sanford Kornwise, MD	D	126
* Steven M. Korotkin, MD	CD	174
* Frank S. Korotney, MD	OBG	098
Henry Kort		090
Walter G. Korytowsky, MD	D	098
* John M. Kosanovich, MD	NEP	190
Herman K. Koschnitzke, MD	IM	222
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Abraham Koshy, MD	CD	026
Betty Koshy, MD	IM	026
* Sudjond Kosim, MD	DR	158
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* Michael E. Kosinski, MD	ORS	222
* Richard P. Kosinski, MD	OM	070
Timothy J. Kosinski, MD	FP	154
* Joseph W. Kosnik, MD	EM	218
* John M. Kosta, MD	OTO	106
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Sujatha Kotamraju, MD	AN	222
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Kusum S. Kothari, MD	PTH	078
* Harry N. Kotsis, MD	U	222
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George J. Kouskoulas, MD	PD	222
* Conchita Q. Kovach, MD	PD	222
Laszlo Kovacsi, MD	U	022
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* Jeffrey J. Kovan, MD	OPH	222
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* Naim Koymen, MD	NS	102
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Anthony E. Kozlinski, MD	GP	222
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Louise E. Kozlow, MD	OBG	174
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E. J. Kozora, MD	OBG	174
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Samson K. Kpadenow, MD	IM	174
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Richard O. Kraft, MD	GS	218
Ruth M. Kraft, MD	PD	222
Bernard Krakauer, MD	ORS	222
Steven K. Kraker, MD	IM	186
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Frank J. Krhovsky, MD	AN	106
* Herbert I. Krickstein, MD	PTH	222
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Morton J. Kripke, MD	OBG	126
Ambujam R. Krishnan, MD	IM	222
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* Michael P. Kucera, MD	PD	218
Lucille K. Kuchera, MD	PH	034
Francis S. Kucmierz, MD	GP	222
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Ned N. Kuehn, MD	PTH	222
Kenneth L. Kuehnl, MD	IM	050
Fook C. Kuet, MD	AN	062
Eli H. Kuhel, MD	PD	174
* Peter A. Kuhl, MD	IM	106
* Shirlee E. Kuhl, DO	PD	174
* James M. Kuhlman, MD	NM	222
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* Scott M. Kuhnert		090
* Jerome L. Kuhnlein, MD	IM	026
* Donald H. Kuiper, MD	IM	090
Walter F. Kujawski, MD	CD	222
Anna Kulczycki		222
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Gregory A. Kuldanek, MD	IM	106
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* Eugene J. Kulinski, MD	IM	022
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* Saroj N. Kulkarni, MD	IM	222
* Anil B. Kumar, MD	U	222
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G. Krishna Kumar, MD	IM	174
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* Neelam B. Kumar, MD	PTH	222
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Kamlesh Kumari-Lobo, MD	OBG	174
* Glen H. Kumasaka, MD	R	218
* Jones O. Kumi, MD	IM	222
Usha B. Kumra, MD	PTH	218
Aruna Kundi, MD	IM	090
* Prem C. Kundi, MD	AN	046
* Vimala E. Kunjappan, MD	AN	222
* Carl E. Kuntzman, MD	OS	174
Surender Kurapati, MD	R	222
* James E. Kure, MD	CD	062
* Leonard J. Kurello, DO	U	162
* Mani Kurien, MD	ON	162
L. E. Kurlandsky, MD	PD	106
* Ruben S. Kurnetz, MD	PD	174
Nancy J. Kursik, MD	FP	062
Debra J. Kurtz, MD	OBG	070
Hyman Kurtz, MD	P	126
* John E. Kurtz, MD	AN	222
* Roberta G. Kurtz, MD	IM	070
Raymond S. Kurtzman, MD	DR	222
* Suryarao Kurumety, MD	R	190
* Lawrence T. Kurz, MD	ORS	174
* Mark R. Kurzawa, MD	FP	126
* Donna M. Kushner, MD	P	222
Kathlene A. Kusiv, DO	OBG	190
Ada B. Kusnetz, MD	AN	174
Nadeem Kutaish, MD	PTH	114
Richard A. Kutcipal, MD	OBG	170
* David O. Kutsche, MD	FP	106
John D. Kutsche, MD	IM	222
William F. Kutsche, MD	GP	095
Sandra M. Kutschke, MD	OBG	106
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* Pradyumna Kuver, MD	IM	062
Benjamin Kvietys, MD	IM	222
* Alan Kwaselow, MD	AI	174
S. A. Kwasiborski, MD	GP	222
* Harold A. Kwast, MD	CD	154
Kang Kwon, MD	P	062
* Young J. Kwon, MD	P	222
George P. Kypros, MD	IM	126
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Thomas A. La Londe, MD	CD	222
* Richard L. La Mont, MD	ORS	222
Allen R. La Reau, MD	PD	102
Carroll J. La Vielle, MD	R	062
Robert J. LaChance, MD	FP	154
James R. LaFleur, MD	FP	190
* Ann A. LaFond, MD	D	222
* Michael J. LaRouere, MD	GS	174
* Armand M. LaSorsa, MD	DR	106
Russell F. Labeau, MD	PD	170
James E. Labes, MD	OBG	174
H. F. Labsan, MD	N	190
* Alan S. Lachniet, MD	ORS	162
Samuel J. Lacina, MD	PD	106
Lawrence S. Lackey, MD	IM	222
Robert Lacoste, MD	P	126
David C. Laderach, MD	OM	222
* Paul A. Lafia, MD	CD	062
Emily A. Lagace, MD	FP	050
* Kamalesh Lahiri, MD	CD	174
Michael J. Lahood, MD	OBG	222
Carl R. Lahti, MD	GP	182
Paul T. Lahti, MD	GS	174
* Albert M. Lai, MD	TS	034
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* Lynn M. Laitinen		222
Dennis L. Lake, MD	PD	106
* Edward C. Lake, MD	OBG	030
Edward C. Lake, MD	OBG	098
* Gordon W. Lakke, MD	OBG	034
* Yash P. Lakra, MD	GS	174
Jeevak Lal, MD	OPH	034
* Niranjan Lal, MD	NEP	102
Sarla Lal, MD	GP	126
Michael K. Lala, MD	R	174
Chitranjan Lall, MD	OBG	222
Rekha Lall, MD	OBG	222
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Charles C. Lam, MD	GP	222
* Richard L. Lam, MD	GS	034
* Timothy J. Lamb		222
Fred S. Lamb, MD	PD	070
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* William R. Lamb, MD	P	014
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Warren C. Lambert, MD	OBG	134
Austin E. Lamberts, MD	NS	106
* Robert J. Lamberts, MD	D	106
Gregory P. Lambourne, MD	IM	226
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* Marc E. Lame, MD	GS	170
* Roland H. Lamkin, MD	OTO	226
* Gerald P. Lammers, MD	GP	158
Thomas G. Lammy, MD	IM	070
Francis W. Lanard, MD	OM	174
Vance B. Lancaster, MD	IM	034
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Tamas A. Lanczy, MD	GP	082
* Ivan R. Landan, MD	N	162
Stephen G. Landau, MD	P	218
* Steven N. Landau, MD	OS	098
* Stuart P. Landay, MD	OPH	090
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* James W. Landers, MD	PTH	222
Maurice B. Landers, MD	OM	222
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Peter A. Lange, MD	IM	118
* Philip F. Lange, MD	FP	090
William A. Lange, MD	PS	222
David Langholz, MD	IM	106
* John L. Langin, MD	PTH	022
John D. Langston, MD	PTH	126
* John M. Lanham, MD	OM	154
* Edward D. Lanigan, MD	PS	090
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* Frank L. Lanuti, MD	GS	034
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* William F. Lapenna, MD	IM	106
Jack Lapides, MD	U	218
Gregory D. Lapinski, MD	GP	098
* Charles J. Lapp, MD	GP	126
Gregory G. Lara		218
* Ethelbert M. Lara, MD	DR	134
* Violeta P. Lara, MD	AN	134
* Horacio G. Lardo, MD	AN	126
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* Donald J. Largo, MD	OM	222
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* Paul E. Larkey, MD	FP	090
Donald F. Larkin, MD	ORS	222
* Edwin R. Larkin, MD	PH	058
Richard I. Larned, MD	GP	222
* David W. Larose, MD	FP	222
* Roberto A. Larrivey, MD	OTO	206
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William C. Larsen, MD	FP	222
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Homer I. Larson, MD	AN	090
James M. Larson, MD	R	106
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* Scott D. Larson, MD	EM	102
* Steven D. Larson, MD	EM	134
* Bruce L. Larva, MD	EM	026
* Steve R. Lasater, MD	FP	106
* Craig Lash		222
Jules C. Lassignal, MD	EM	190
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* Sandra P. Last, MD	R	106
* Marvin Latchana, MD	IM	062
* Andrew W. Latham, MD	EM	102
* James C. Lathrop, MD	GS	190
Khalid Latif, MD	R	062
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Karl K. Latteier, MD	R	222
* Paul B. Lattin, DO	RO	222
* Paul R. Lauber, MD	R	062
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Cela L. Laughlin, MD	GYN	090
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Albert L. Laura, MD	IM	222
* John M. Laurain, MD	IM	190
A. Gregory Laurell, MD	DR	102
Emil J. Lauretti, MD	GS	162
Lawrence A. Lauretti, MD	OBG	162
James Lauridsen, MD	GS	194
Helen Lausz, MD	IM	126
* Carl B. Lauter, MD	ID	174
Philip J. Laux, MD	PD	174
Paul S. Laven, DO	FP	174
* J. Patrick Lavery, MD	OBG	102
Kevin T. Lavery, MD	OPH	098
Larry L. Lawhorne, MD	FP	074
Gordon T. Lawless, MD	R	222
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James O. Lawrence, MD	FP	102
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Mary E. Lazar, MD	IM	222
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Robert J. Lazar, MD	IM	070
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* Leslie L. Le Mieux, MD	IM	062
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* William A. Le Mire, MD	GYN	050
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Harold R. Leach, MD	OBG	174
* Richard E. Leach, MD	OBG	222
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* Sue A. Lee		222
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* Byung S. Lee, MD	IM	126
* Chang Y. Lee, MD	OBG	062
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Thomas E. Lee, MD	PD	126
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* William R. Lee, MD	ORS	218
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* Thomas D. Legalley, MD	CD	134
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* Robert J. Leonard, MD	HEM	222
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* Ronald W. Leong, MD	IM	102
Jack M. Leopard, MD	GS	014
Olin L. Lepard, MD	FP	198
Victor E. Lepisto, MD	OPH	082
* Frederick J. Lepley, MD	OPH	222

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Leppink

* Richard A. Leppink, MD	IM	186
* Edward S. Lerchin, MD	D	126
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Edward B. Leverich, MD	OBG	090
Harry L. Levett, MD	OTO	090
* Charles S. Levi, MD	OPH	174
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* Kenneth J. Levin, MD	RO	174
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* Jai D. Liem, MD	PM	222
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Herman J. Linn, MD	PTH	222
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* Paul C. Linnell, MD	OPH	090
David S. Lint, MD	ORS	070
* Geoffrey M. Linz, MD	IM	090
* Judith T. Lipinski, MD	D	222
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* Stephen A. Liroff, MD	U	222
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* Charles G. Lischer, MD	ORS	026
* David M. Liscow, MD	FP	214
* Diana Little, MD	OBG	218
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C. S. Livingood, MD	D	222
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* Gustav M. Lo, MD	P	090
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* Kenneth E. Lobbes, MD	AN	106
* Paul F. Lobert, MD	PTH	162
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Leonel L. Loder, MD	OPH	162
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* Lawrence S. Loesel, MD	PTH	070
L. M. Loewenthal, MD	OPH	126
* Konstantin R. Loewig, MD	DR	106
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* Mary S. Logan, MD	PD	222
Samuel E. Logan, MD	PS	026
Wesley G. Logan, MD	OBG	018
James W. Logie, MD	GS	106
* Linda J. Logsdon, MD	P	174
* William K. Loh, MD	AN	222
Carl W. Lohmann, MD	OTO	222
* Thomas O. Lohr, MD	IM	190
* Michael A. Lojek, MD	IM	106
Carter O. Lomax, MD	OBG	102
* Kenneth A. Lombardi, MD	IM	034
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Jeffrey A. London, MD	CHP	174
* John L. London, MD	FP	094
Charles O. Long, MD	R	090
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* Kathleen M. Longo, MD	IM	218
Curtis Longs, MD	P	222
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* Karl F. Loomis, MD	PTH	034
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* William C. Loop, MD	IM	095
David A. Lootens, MD	IM	218
Reuben Lopatin, MD	IM	222
* Alfonso A. Lopez, MD	GS	026
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* Gerald L. Lopez, MD	OM	174
* Glicerio B. Lopez, MD	IM	034
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* H. M. Lopez-Negrete, MD	NS	062
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Harry J. Loughrin, MD	OBG	090
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* James T. Love, MD	CCM	222
* John R. Love, MD	D	062
* F. Raymer Lovell, MD	GS	106
* James R. Lovell, MD	GYN	134
* Raymond J. Lovett, MD	ORS	106
Rose Lovio		222
W. Carter Lowe, MD	IM	102
* James W. Lowell, MD	DR	174
* James Lowery		222
Paul L. Lowinger, MD		222
John F. Loyd, MD	IM	170
James W. Loynd, MD	OBG	102
* John Lozak, MD	DR	154
Alberto T. Lozon, MD	AN	206
* Patricia S. Lozon, MD	AN	222
Jean Lu-Olendorf		090
* Konrads V. Lubavs, MD	GS	102
* Richard J. Lubera, MD	IM	126
* Harry S. Lubetsky, MD	D	118
* Michael R. Lubetsky, MD	IM	174
* Elliot D. Luby, MD	P	222
* Barbara A. Lucas, MD	PD	222
* Charles E. Lucas, MD	GS	222
* Mark A. Lucas, MD	U	102
* Michael J. Lucas, MD	GS	174
Paul M. Lucas, MD	P	134
Stephanie M. Lucas, MD	IM	222
William R. Lucas, MD	OPH	222
* Martin A. Luchtefeld, MD	GS	106
John R. Luderer, MD	IM	102
John P. Ludwick, MD	GP	170
Ellsworth E. Ludwig, MD	GS	154
Frederick E. Ludwig, MD	GS	042
Frederick E. Ludwig, MD	FP	194
Robert M. Lugg, MD	PD	194
* Jay A. Lugthart, MD	EM	106
* Jeffrey L. Lukas, MD	FP	222
Henry J. Lukaszek, MD	DR	214
Jack G. Lukens, MD	IM	106
* Mark L. Lukens, MD	DR	222
* Theodore J. Lukens, MD	P	062
* James R. Lulek, MD	GS	222
Gary C. Lulenski, MD	OTO	026

Lulenski

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* Eleuterio R. Lumaque, MD	GS	062
Rosie M. Lumaque, MD	PD	062
John G. Lumpkin, MD	PD	222
Patricia M. Lundeberg, MD	EM	218
* John G. Lundeen, MD	R	106
Peter B. Lundeen, MD	FP	106
* Richard M. Lundeen, MD	FP	062
* Larry B. Lundy, MD	OS	174
* David M. Luoma, MD	FP	134
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* Aaron Lupovitch, MD	CLP	222
Robert I. Lurie, MD	U	190
Alexsandrs Lusis, MD	GP	096
John A. Lusk, MD	CD	062
Arthur S. Lussos, MD	GP	174
* Byron B. Lutes, MD	CRS	190
* Edward R. Lutkus, MD	EM	162
* Charles R. Luttenton, MD	DR	106
* Roderico Luttmann, MD	PD	222
Earl F. Lutz, MD	OM	222
Michael D. Lutz, MD	U	222
Sherwin J. Lutz, MD	U	222
* Asuncion Q. Luz, MD	PDA	114
John H. Luzadre, MD	OBG	222
David J. Lyman, MD	FP	102
James E. Lynch, MD	R	106
James P. Lynch, MD	CRS	174
Harvey D. Lynn, MD	OBG	222
* Carol K. Lyon, MD	IM	090
James W. Lyons, MD	ORS	134
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Marson M. Ma, MD	EM	222
* Gerald I. Maas, MD	IM	098
* Luis C. Maas, MD	IM	174
Hayward C. Maben, MD	TS	222
L. Joy Mac Donald, MD	FP	174
* Lawrence L. Mac Donald, MD	IM	222
* M. A. Mac Donald, MD	AI	102
* Nancy L. Mac Donald, MD	PD	186
William B. Mac Donald, MD	R	174
* David B. Mac Dougall, MD	IM	222
John F. Mac Gregor, MD	GS	206
Dugald S. Mac Intyre, MD	GS	106
* I. Donald Mac Kay, MD	RO	126
* James C. Mac Kenzie, MD	IM	174
* James R. Mac Kenzie, MD	PM	070
John W. Mac Kenzie, MD	FP	062
Kenneth M. Mac Kinnon, MD	FP	154
John A. Mac Neal, MD	GP	078
* James E. Mac Vicar, MD	OPH	102
* Frankie E. Mac, MD	U	174
* John S. MacDonald, MD	IM	046
Orrin P. MacDougall, MD	U	222
* John M. MacKeigan, MD	CRS	106
Tomas A. Macatangay, MD	PD	126
* Douglas W. Macdonald, MD	OS	174
* Djen X. Mach		222
* Jennifer J. Mach		222
Mohan Dass Macha, MD	GS	202
* K. L. Machiorlat, MD	PTH	106
Thomas R. Macholan, MD	FP	106
* Algimantas P. Maciulis, MD	IM	022
* Margarethe Maciulis, MD	IM	022
* Douglas A. Mack, MD	PH	106
George J. Mack, DO	TS	102
* Robert E. Mack, MD	OS	222
* Vincent A. Macke, MD	AN	070
* Hugh L. Mackechnie, MD	AI	222
Vladimir V. Mackedonski, MD	CLP	198
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* George S. Mackey, MD	IM	174
* Victoria L. Macki, MD	FP	122
* Robert H. Mackie, MD	FP	042
Thomas B. Mackie, MD	IM	042
Irene Macko, MD	IM	222
* Albert J. Macksood, MD	VS	062
* John M. Macksood, MD	AN	062
* Michael J. Macksood, DO	GS	062
* William E. Macksood, MD	GS	062
* Judy A. Macy, MD	PM	158
Chandramouli Madala, MD	IM	034
* Lakshmana R. Madala, MD	AN	190
* Leo M. Madarang, MD	GS	062
* Gene E. Maddock, MD	R	026
Aaron W. Maddox, MD	IM	222
* Ivan J. Mader, MD	IM	174
Tom Madhavan, MD	IM	174
* Matthew Madion, MD	OPH	070
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* Khalid M. Malik, MD	GS	190
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Edward Malinowski, MD	IM	222
Marlyn Malit, MD	P	222
Frank J. Malje, MD	PD	222
* Robert G. Mallen, MD	IM	106
* Veronica T. Mallett, MD	OBG	222
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* Amorn Manadee, MD	AN	222
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Vasudeva R. Mandava, MD	IM	126
Leslie Mandel, MD	IM	222
* Robert Mandel, MD	AN	034
* Bernard A. Mandelbaum, MD	OBG	222
* Gerald H. Mandell, MD	PTH	222
Sharon L. Mandell, MD	FP	126
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* Tejinder S. Mander, MD	IM	106
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John W. Manning, MD	GS	190
* Anand M. Manohar, MD	ORS	030
Joseph M. Manoharan, MD	IM	062
B. M. Manshady, MD	IM	222
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Yousif S. Mansour, MD	IM	222
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Bayani L. Manzano, MD	DR	054
* Dayle L. Maples, MD	ORS	106
* R. N. Maragiri, MD	IM	022
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* Manfred Marcus, MD	GS	218
Edo V. Marcuz, MD	OBG	126
Arlene M. Marcy, MD	OBG	174
* Curtis C. Marder, MD	CDS	134
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R. Ralph Margulis, MD	OBG	174
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* Federico G. Mariona, MD	OBG	222
Jerome Mark, MD	GS	222
* Joseph E. Mark, MD	PS	174
* Maria A. Markarian, DO	IM	090
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* Thomas S. Markus, MD	OBG	022
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Percy S. Marsa, MD	GP	174
Don Marshall, MD	OPH	102
* Joseph F. Marshall, MD	OBG	190
* Nancy H. Marshall, MD	P	222
Robert B. Marshall, MD	R	106
* Thomas J. Marshall, MD	FP	014
William P. Marshall, MD	AN	102
William Martel, MD	R	218
Lee Ann Martin		218
Bruce W. Martin, MD	FP	186
Carolyn G. Martin, MD	FP	090
* David B. Martin, MD	ID	070
David E. Martin, MD	TS	222
* Donald J. Martin, MD	GS	114
Donald W. Martin, MD	P	174
Jack F. Martin, MD	ORS	190
* James A. Martin, MD	FP	062
* Peter A. Martin, MD	P	222
Richard W. Martin, MD	RHU	106
Robert G. Martin, MD		170
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Pamela Mazzoline, MD	P	090
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* Michael K. Mc Alvey, MD	FP	018
Peter A. Mc Arthur, MD	FP	186
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Leo B. Mc Sherry, MD	AN	022
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* J. Wesley Mesko, MD	ORS	090
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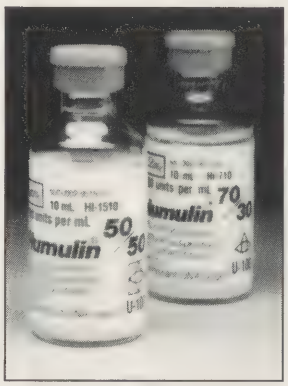
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* Usha R. Modi, MD	IM	062
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* Marjan Mohamadi, MD	IM	030
* Darioucbe Mohammadi, MD	GS	126
* Kanwal Mohan, MD	A	090
Kochunni K. Mohan, MD	IM	190
Ponniah Mohan, MD	PD	126
Syed G. Mohiuddin, MD	PD	110
Glenn E. Mohney, MD	OPH	194
* Russell E. Mohney, MD	N	102
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Mohammad Mohsenian, MD	OBG	090
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* Melvin C. Murphy, MD	IM	222
* Miles J. Murphy, MD	OBG	106
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* Thomas Neidlinger, MD	FP	034
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* Dana A. Ohl, MD	U	218
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* David L. Ohmart, MD	PD	010
* Galen D. Ohmart, MD	OTO	014
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Ann L. Oldendorf, MD	U	218
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Harvey A. Olds, MD	PD	062
Mary R. Oldt, MD	PTH	062
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Sezai M. Olgac, MD	PD	022
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* Timothy D. Oliver, MD	FP	206
* Randy S. Olli, MD	FP	134
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Bruce C. Olsen, MD	FP	162
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Darla M. Olson, MD	OBG	106
David L. Olson, MD	FP	150
* David S. Olson, MD	PD	070
James A. Olson, MD	OPH	222
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* Robert M. Oneal, MD	PS	218
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O. Abraham Oommen, MD	IM	074
* Anne F. Oostendorp, MD	PDR	106
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Donna L. Opie, MD	PD	174
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* Jesus Ortega, MD	IM	222
* Armando Ortiz, MD	NS	222
* Eduardo Ortiz, MD	OBG	114
Rafael I. Ortiz, MD	AN	190
* Rustico B. Ortiz, MD	IM	190
* Brian L. Ortman, MD	ORS	062
* Ralph W. Ortwig, MD	OTO	106
Gabriel S. Orzame, MD	FP	026
Nilda D. Orzame, MD	IM	026
Robert W. Orzechowski, MD	IM	126
* Gregory V. Osborne, MD	GE	106
* Theresa A. Osborne, MD	IM	106
* Geoffrey D. Osgood, MD	PS	194
David L. Osher, MD	DR	222
* Richard R. Oslund, MD	R	162
* Robert L. Osmer, MD	GS	206
Luis Ospina, MD	IM	174
Mark S. Ostahowski, MD	FP	154
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* Luis E. Osterberger, MD	CD	222
* Janet R. Osuch, MD	GS	090
Marjorie H. Otero, MD	PD	062
* Renato A. Oteyza, MD	GS	218
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Frederick D. Ott, MD	D	014
Harold A. Ott, MD	OBG	174
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* S. E. Ottenweller, MD	GS	106
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* Kenneth A. Otto, MD	OPH	162
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Mustafa E. Ovacik, MD	PD	218
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* Donald Paarlberg, MD	ORS	030
* James D. Paauw, MD	GS	106
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* Anthony Pacek, MD	IM	218
Robert L. Pacer, MD	IM	070
Marc Pacho, MD	GP	126
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Larry L. Pack, MD	ORS	062
James E. Packer, MD	FP	190
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* Robert C. Padilla, MD	IM	174
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* Gordon A. Page, MD	GP	095
* Robert B. Page, MD	PD	102
Jon D. Paget, MD	FP	090
* Edgardo G. Paguio, MD	R	062
* Jaak M. Pahn, MD	FP	042
* Gena R. Pahucki, MD	OBG	218
Divakar Pai, MD	IM	174
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* Butchi B. Paidipaty, MD	IM	222
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* Choon Whan Pak, MD	AN	174
* Moon J. Pak, MD	IM	174
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Carl E. Palffy, MD	IM	174
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* Harry T. Pall, MD	AN	170
* Peter Palmer, MD	ORS	222
* Steven S. Palmer, MD	OPH	106
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* Randal A. Palmitier, MD	PM	106
* Fouad Panah, MD	R	174
Jalal Panah, MD	OBG	174
* Parviz Panahi, MD	PD	218
* Sujit K. Pandit, MD	AN	218
Sunil P. Pandit, MD	AN	190
* Vinenda T. Pandjaitan, MD	OBG	026
Haresh B. Pandya, MD	PD	094
* Harivallabh Pandya, MD	IM	222
Pragna H. Pandya, MD	PD	094
J. Rajkumer Pandyan, MD	GS	062
Rajeevi Pandyan, MD	OBG	062
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P. H. Pangilinan, MD	GS	222
* Sandhya Panguluri, MD	IM	222
Hussein H. Panju, MD	IM	222
Dennis J. Pank, MD	FP	062
* Dana D. Panknin, MD	FP	014
Douglas G. Pankratz, MD	ORS	086
Sambhu P. Pant, MD	GP	222
* L. Pantig-Felix, MD	IM	126
Nana N. Pantos, MD	OBG	222
* Theodore G. Pantos, MD	U	222
Daniel E. Panush, MD	IM	174
* John M. Pap, MD	IM	134
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* Helen A. Papaioanou, MD	AI	222
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Michael A. Papo, MD	IM	218
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* Michael D. Pappas, MD	PD	222
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* Tushar S. Parikh, MD	DR	222
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Anthony M. Parillo, MD	R	062
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* S. William Paris, MD	A	174
Chan Kee Park, MD	OBG	126
* Chanok H. Park, MD	IM	126
* Che S. Park, MD	CRS	190
* Chong Hoon Park, MD	IM	118
* Hee D. Park, MD	GS	062
Helen C. Park, MD	OBG	118
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** Asterisk beside name denotes AMA membership*

Park

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* Ro Jong Park, MD	GS	198
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Sheryl L. Parks, MD	OBG	222
* Burt A. Parliament, MD	GS	062
Michael D. Parmer, DO	GP	226
Leo Parnagian, MD	GS	126
Anthony J. Parnello, MD	OBG	090
Kris Parnicky, MD	FP	222
Rufus H. Parrish, MD	P	222
Eleanor M. Parshall, MD	FP	114
Cheryl L. Parsons, MD	FP	014
* Mary H. Parsons, MD	IM	222
* Richard W. Partridge, MD	R	106
* S.R.A. Paruchuri, MD	AN	190
* David L. Paschall, MD	OBG	190
* Arturo V. Pascual, MD	IM	222
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* Arun G. Patel, MD	DR	222
* Arvindkumar U. Patel, MD	AN	222
Atulkumar S. Patel, MD	IM	174
B. G. Patel, MD	FP	174
Bharat K. Patel, MD	IM	222
Chandravadan A. Patel, MD	PD	126
Daxika A. Patel, MD	PD	222
Ghanshyam N. Patel, MD	IM	126
* Hasmukh I. Patel, MD	R	090
Jashu R. Patel, MD	CD	098
* Jashubhai N. Patel, MD	GS	038
* Kapilbhai C. Patel, MD	PD	222
* Kiritkumar C. Patel, MD	IM	174
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* Madhubala C. Patel, MD	R	222
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* Narendra R. Patel, MD	N	090
* Piyush C. Patel, MD	R	098
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* Renuka M. Patel, MD	DR	222
* Rohane A. Patel, MD	D	174
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* Sudhanshu H. Patel, MD	IM	222
* Suman Patel, MD	FP	222
Suresh C. Patel, MD	R	222
Taru P. Patel, MD	FP	106
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* Vishnubhai U. Patel, MD	GS	174
* Blake M. Paterson, MD	AN	218
Lester C. Paterson, MD	PD	162
* Roger D. Paterson, MD	FP	130
* Khushal D. Patil, MD	CDS	102
* Lingraj S. Patil, MD	PUD	174
* Martin C. Patrias, MD	OPH	098
Rebecca L. Patrias, MD	IM	218
* Michael A. Patt, MD	AN	174
* Gregg A. Patten, MD	PUD	098
* Cheryl A. Patterson, MD	AN	222
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* Lawrence H. Patzelt, MD	TS	106
* Lloyd J. Paul, MD	IM	222
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* Sander J. Paul, MD	IM	174
* Francis J. Pauli, MD	R	218
* Jose M. Pavia, MD	GP	222
* Lawrence E. Pawl, MD	IM	106
Jerome I. Pawlowski, MD	IM	222
* Robert E. Paxton, MD	FP	166
Norman P. Payea, MD	GP	095
* Richard P. Payea, MD	FP	095
Andrew K. Payne, MD	R	098
Beverly C. Payne, MD	IM	218
C. Allen Payne, MD	PTH	106
Charles E. Payne, MD	P	026
* David H. Payne, MD	IM	226
* Thomas C. Payne, MD	R	090
Walter A. Payne, MD	IM	222
Charles F. Payton, MD	PD	174
* Patricia Paz		222
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* Edward Pazuchowski, MD	FP	126
* Charles O. Peake, MD	OBG	102
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* Mark D. Pearlman, MD	OBG	218
* Martin E. Pearlman, MD	OPH	090
Ralph D. Pearlman, MD	GS	174
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Donald J. Pearson, MD	CRS	034
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* Marlin J. Pearson, MD	P	218
Stanley M. Pearson, MD	GP	022
Wallace G. Pearson, MD	OBG	134
* Rodney D. Pease, DO	AN	106
Aida Pech, MD	PD	222
* Stephen L. Peck, MD	CD	102
John R. Pedden, MD	IM	106
Leon E. Pedell, MD	IM	174
Alicia A. Pedelty, MD	GP	166
Norman L. Pedelty, MD	GP	166
* B. L. Pederson, MD	OBG	022
J W. Peelen, MD	OBG	102
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James F. Peggs, MD	FP	218
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Walter E. Pelczar, MD	AN	022
* Robert R. Peleman, MD	AN	126
* Tamara L. Pelish, MD	OBG	218
* Paula M. Pelkola		090
Larry R. Pelok, MD	CRS	222
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Emilio F. Pena, MD	CD	158
George V. Pendy, MD	ORS	222
John M. Pendy, MD	ORS	222
* Jane F. Penet		222
Regio T. Penna, MD	CLP	030
John A. Penner, MD	IM	090
* J. S. Pensavecchia, MD	AN	174
* Mark I. Pensler, MD	PUD	222
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* Mohammad H. Peracha, MD	OPH	158
Manuel M. Perea, MD	GS	190
Ceneca T. Perez, MD	GS	046
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Luisa F. Perez, MD	PTH	174
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* David A. Pesola, MD	IM	134
* Josip Petani, MD	PD	095
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* Richard W. Peters, MD	PTH	162
David P. Petersen, MD	GS	106
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Carl A. Peterson, MD	FP	078
* Edward N. Peterson, MD	GS	106
* Edwin P. Peterson, MD	OBG	218
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* Frank L. Pettinga, MD	GP	162
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* Clark D. Phelps, MD	R	070
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* Brian V. Phillips, MD	FP	106
* David Phillips, MD	DR	022
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* James E. Phillips, MD	FP	198
* Reginald W. Phillips, MD	FP	118
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* Roger A. Phillips, MD	IM	186
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* Sol D. Pickard, MD	IM	222
Alex D. Pickens, MD	OBG	222
* Leonard M. Pickering, MD	ORS	222
Woodrow H. Pickering, MD	FP	062
* Daniel E. Pickle, MD	AN	102
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* Kevin L. Piggott, MD	FP	134
* Leonard R. Piggott, MD	CHP	222
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Donald G. Pike, MD	OTO	070
* Lennox A. Pike, MD	AN	222
Wallace W. Pike, MD	FP	062
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* Michael H. Piper, MD	GE	126
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Mehmet S. Piskin, MD	IM	106
* Pornchai Pisutha-Arnond, MD	IM	030
* Andrew D. Pitonyak, MD	AN	174
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* Richard A. Pittsley, MD	IM	090
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* John F. Plant, MD	OPH	090
* Dale M. Plapp, MD	FP	010
Efren F. Platon, MD	IM	174
* Teresita S. Platon, MD	IM	222
Alice L. Platt, MD	EM	062
Carol K. Platz, MD	GYN	222
* Mark A. Pleatman, MD	GS	222
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Harold Pliskow, MD	OPH	222
* Alan E. Plona, MD	AN	218
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* Christopher J. Pogliano, MD	FP	066
Senta V. Poim, MD	P	222
* Ilydio Polachini, MD	N	102
* Emery C. Polasek, MD	FP	102
Jamie A. Poliskey, MD	FP	154
* George D. Politis, MD	PD	062
John E. Polk, MD	GP	222
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* Charles R. Pollard, MD	FP	138
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Louis S. Pollens, MD	IM	222
Steven M. Pollens, MD	FP	102
Jeffrey L. Pollet, MD	PD	114
* Frank S. Pollina, MD	PM	126
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Richard W. Pomeroy, MD	ORS	090
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* Anne G. Pond, MD	CHP	222
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Joseph L. Ponka, MD	GS	222
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Sergio A. Ponze, MD	IM	074
* Lee R. Pool, MD	GS	106
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* Robert J. Porter, MD	TS	162
* Leonard J. Portner, MD	FP	174
* Jack E. Portney, MD	FP	062
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Arsenio G. Posada, MD	GP	222
Juan G. Posada, MD	GP	222
Luis C. Posada, MD	NS	090
Roberto G. Posada, MD	GS	222
Vicente T. Posadas, MD	AN	194
Robert C. Posey, MD	OBG	090
Gary A. Posner, MD	FP	154
Irving Posner, MD	PH	222
Christine Post, DO	P	222
J. Jay Post, MD	FP	186
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Jack R. Postle, MD	OBG	170
Edward Y. Postma, MD	OBG	106
Howard F. Postma, MD	OBG	106
* Richard C. Postma, MD	U	106
Roger W. Postmus, MD	OBG	218
* E. James Potchen, MD	R	090
* A. James Potter, MD	OTO	162
* Darrell J. Potter, MD	ORS	142
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Michael J. Potter, MD	OPH	062
Roger A. Potter, MD	D	222
* William P. Potthoff, MD	GS	070
Elihue B. Potts, MD	OBG	222
* Maurice B. Potts, MD	OBG	222
Michael J. Potts, MD	PD	050
* Gomer J. Pound, MD	EM	038
Thomas K. Pow, MD	IM	026
* J. Thomas Powaser, MD	PTH	222
* Matthew A. Powell		090
Carl E. Powell, MD	GS	034
* Isaac J. Powell, MD	U	222
* Guy C. Power, MD	IM	162
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* Walter A. Poznanski, MD	P	174
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* Richard L. Prager, MD	TS	218
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* Ananda S. Prasad, MD	IM	222
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* Ashok R. Prasad, MD	IM	222
* J M. Prasad, MD	IM	190
* Jai K. Prasad, MD	GS	218
* Jwala Prasad, MD	IM	090
* Prem S. Prasad, MD	P	222
Rajendra Prasad, MD	CD	174
Sudhir Prasad, MD	IM	162
Vikram Prasad, MD	FP	118
Perry E. Prather, MD	OBG	190
V. B. Prathikanti, MD	GS	062
Lawrence A. Pratt, MD	TS	222
Constantin Predeteanu, MD	D	174
* Ruben Preide, MD	P	126
* Richard C. Preisman, MD	P	222
* Daniel V. Prendeville, MD	OPH	022
* Laura B. Prescott, MD	IM	150
Cheston E. Price		090
* Julie Price		222
* Jack R. Price, MD	OBG	062
* Joan P. Price, MD	IM	222
Joseph M. Price, MD	FP	202
Lee J. Price, MD	IM	106
Gabriella C. Pridjian, MD	OBG	218
John S. Pridmore, MD	IM	174
Linnea J. Priest, MD	R	070
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* Carol Prince, MD	EM	222
Richard W. Prior, MD	OM	062
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Julien Priver, MD	OS	222
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* Conrad A. Proctor, MD	OTO	174
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Frank P. Prokop, MD	IM	222
John M. Proos, MD	FP	026
* Richard A. Proos, MD	IM	102
* Robert C. Prophater, MD	GP	022
* Cecilia M. Prophit, MD	OTO	102
Russel F. Proud, MD	FP	222
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Donald Prouty, MD	FP	074
* Robert Provenzano, MD	IM	222
* Poala D. Prude-Bogar, MD	FP	062
* A. Michael Prus, MD	AN	222
* Vincent R. Prusick, MD	ORS	070
Lawrence B. Prussack, MD	OBG	174
Frank W. Prust, MD	GS	174
* Robert M. Prust, MD	TR	070
Andrew W. Prychodko, MD	IM	174
Robert B. Pryor, MD	GP	018
* Michael F. Prysak, MD	OBG	222
* Sidney N. Prystowsky, MD	IM	222
* Thomas J. Przybylski, MD	GS	174
* Philip C. Ptacin, MD	FP	034
* Michael D. Puchalski		222
* Micheal R. Puff, MD	IM	106
Andre V. Pugel, MD	N	222
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Robert H. Puite, MD	IM	106
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* James E. Puklin, MD	OPH	222
* Mark W. Puls, MD	GS	014
Francis L. Purcell, MD	OM	218
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* Les M. Puretz, DO	EM	090
William P. Purfield, MD	FP	114
Kasturi B. Puri, MD	PM	222
Pritpal S. Puri, MD	CD	222
* Sarla Puri, MD	PTH	106
Suresh Puri, MD	PD	106
Vimal P. Puri, MD	EM	222
Stewart E. Pursel, MD	TS	174
George B. Pusczak, MD	IM	142
* V. P. Puttagunta, MD	AN	062
John C. Putz, MD	ORS	090
David H. Pyatt, MD	OBG	062
* Scott R. Pynnonen, MD	FP	082
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Ghulam Qadir, MD	P	222
* John F. Quertermus, MD	IM	102
* Ernesto B. Quiachon, MD	PTH	150
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* Mary H. Quigg, MD	OBG	222
Donald R. Quigley, MD	OBG	090
Eugene H. Quigley, MD	GS	222
* David Quimby, MD	PUD	106
* John Quin, MD	IM	062
* Fe F. Quines, MD	FP	210
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Rafael E. Quinones, MD	GS	222
Rodolfo L. Quion, MD	GS	026
* Antonio Quiroga, MD	NS	222
* Pablo J. Quiroga, MD	OBG	090
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Nicolas Radoiu, MD	IM	222
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James W. Rae, MD	PM	070
Douglas J. Raedy, DO	OTO	102
Iraj Rafani, MD	OBG	174
Abdullah Raffee, MD	IM	062
* Muhammad Rafi, MD	HEM	034
* Michael Raftery, MD	IM	194
* Russell M. Ragan, MD	FP	096
Christopher P. Raggio		222
Moufid Ragheb, MD	CD	126
* Samir M. Ragheb, MD	TS	126
* Abner I. Ragins, MD	IM	174
Terry E. Ragland, MD	EM	218
* Homayoon Rahbari, MD	DMP	158
* Raymond P. Rahi, MD	DR	222
* Siamak A. Rahimi, MD	PTH	186
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* Mohammad A. Rahman, MD	GS	102
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* Frank P. Raiford, MD	FP	222
Bhargavi T. Raiji, MD	R	062
Tushar N. Raiji, MD	IM	062
* James A. Raikes, MD	PM	222
* Paavan P. Railan, MD	IM	126
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* Arthur L. Raines, MD	ORS	222
* William H. Raino, MD	N	102
E. G. Raj, MD	IM	062
* Naseer M. Raja, MD	AN	222
A. O. Rajagopal, MD	AN	190
Ramegowda Rajagopal, MD	CD	222
* Vasantha Rajagopal, MD	GP	190
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* Ratan Rajani, MD	GS	110
Paul T. Rajasekhar, MD	IM	014
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* Penumetsa R. Raju, MD	AN	190
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* D. V. Ramana, MD	U	110
* A. S. Ramasamy, MD	IM	198
* M. A. Ramasamy, MD	OBG	198
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* Joseph J. Rambo, MD	FP	026
* Timmiah Ramesh, MD	IM	222
* Vijaya C. Ramesh, MD	P	222
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Benjamin S. Ramirez, MD	PD	062
Jaime Ramirez, MD	IM	222
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* John M. Ramocki, MD	OPH	222
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* Hernando Ramos, MD	PS	102
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* Bobbi J. Ramp, MD	GS	062
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* Richard M. Rankl, MD	FP	062
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* Lori S. Ranval, MD	OBG	174
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* Jehangir N. Rao, MD	IM	222
* Katikineni V. Rao, MD	PD	098
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* Minoo K. Rao, MD	TS	190
* Naraharisetty V. Rao, MD	AN	062
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Venkat K. Rao, MD	PUD	062
* Zerin J. Rao, MD	DR	174
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* Lawrence G. Rapp, MD	NS	174
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Seymour L. Rapp, MD	GS	222
* Steven M. Rapp, MD	NS	174
Richard L. Rapport, MD	TS	062
* Christopher J. Rasak, MD	FP	222
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* Abdul Rasheed, MD	OBG	214
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* Vaneerat P. Ratanathar, MD	R	222
* John M. Ratchford, MD	IM	162
Robert J. Rathburn, MD	EM	062
* Christopher J. Rathfoot	GS	090
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Frederick W. Rau, MD	GS	222
Sanford J. Rautbort, MD	PUD	174
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* Kaushik J. Raval, MD	P	174
Pramod M. Raval, MD	IM	222
* Edith V. Ravasz, MD	IM	126
Clara Raven, MD	CLP	222
S. R. Ravi, MD	PD	214
* Valiya V. Ravi, MD	GE	222
* Thammadi Ravikant, MD	GS	174
* K P. Ravikrishnan, MD	IM	174
* K. K. Ravindran, MD	CD	190
Louis A. Ravitz, MD	GP	222
* Harish Rawal, MD	NS	098
* James R. Rawlinson, MD	FP	090
Amos P. Rawson, MD	GP	114
Larry F. Rawsthorne, MD	IM	090
* Frank S. Ray		090
Asit K. Ray, MD	PM	222
Dean K. Ray, MD	GS	026
* Kenneth J. Ray, MD	GP	222
Sheila M. Ray, MD	OTO	070
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* Licia L. Raymond, MD	OBG	134
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* Floro V. Rayos, MD	IM	222
* M. A. Razzaque, MD	IM	222
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* Gunda S. Reddy, MD	IM	110
* Juvaala M. Reddy, MD	P	174
* Kallam S. Reddy, MD	AN	222
* Madhusudhan C. Reddy, MD	IM	194
* P. Banda Reddy, MD	IM	222
* Prabhaker N. Reddy, MD	GS	126
* Sadasiva T. Reddy, MD	R	098
Sadda V. Reddy, MD	NS	062
* Sudarshan R. Reddy, MD	PS	126
Sushma Reddy, MD	IM	194
Valluru C. Reddy, MD	IM	022
* Vangala P. Reddy, MD	OBG	030
* Vinay N. Reddy, MD	PD	174
Benjamin Reder, MD	IM	222
W. Earl Redfern, MD	IM	222
Stephen D. Redman, MD	FP	154
* William B. Redmon, MD	ORS	154
* Michael J. Redmond, MD	D	222
* David G. Reed, MD	FP	126
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* Jesse H. Reed, MD	FP	158
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* Melvin L. Reed, MD	IM	222
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Joseph J. Reichman, MD	IM	190
* John H. Reid, MD	PD	062
* Michele I. Reid, MD	P	222
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* Robert E. Reid, MD	OBG	174
Alan A. Reidinger, MD	R	174
* William U. Reidt, MD	IM	126
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James R. Reif, MD	OBG	154
Morris V. Reiff, MD	GP	222
* David M. Reifler, MD	OPH	106
* T. J. Reigel, MD	PD	102
* Frederick C. Reigle, MD	GP	030
* Richard C. Reilly, MD	ORS	174
* Nick J. Reina, MD	PM	194
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* Conrad J. Reinhard, MD	OBG	062
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* Melvin J. Reinhart, MD	P	218
* F. T. Reinick, MD	ORS	102
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* Bruce M. Reinoehl, MD	EM	090
* P. Graydon Reinoehl, MD	FP	214
* Earl J. Reisdorff, MD	EM	090
Albert H. Reisig, MD	IM	158
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* Claude R. Reitelman, MD	U	222
* Maurice S. Reizen, MD	PH	090
Bernard Z. Reizner, MD	R	098
* Crispo G. Rejano, MD	GP	222
William R. Rekshan, MD	R	218
* Richard C. Relken, MD	OBG	194
* Geoffrey M. Remes, MD	R	090
Richard J. Remsberg, DO	FP	074
James E. Remski, MD	GS	222
* Louis C. Remynse, MD	U	034
* Jonathan Rene, MD	RHU	190
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Fredric A. Reyelts, MD	FP	106
* David C. Reyes, MD	TS	022
* Eduardo L. Reyes, MD	IM	062
Gerardo D. Reyes, MD	GS	190
* Isabello C. Reyes, MD	IM	174
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Milagros P. Reyes, MD	IM	222
* Pablo Reyes, MD	CD	222
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* Robert M. Reynolds, MD	GS	222
Carole Rgas		218
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* George E. Rhiness, MD	R	090
* Charles H. Rhodes, MD	GS	026
* Robert S. Rhodes, MD	OM	218
* Mohammad Riahi, MD	TS	106
Laura J. Rice		090
Alan K. Rice, MD	OPH	062
* James J. Rice, MD	GS	162
John W. Rice, MD	GP	098
Meshel Rice, MD	GP	222
Robert G. Rice, MD	PH	090
* William J. Rice, MD	OTO	222
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Elizabeth J. Rich, MD	N	218
James E. Richard, MD	PTH	090
Robert C. Richard, MD	FP	106
Robert E. Richard, MD	PD	174
Frank D. Richards, MD	GP	090
James P. Richards, MD	FP	014
Kathryn E. Richards, MD	GS	218
Maurice A. Richards, MD	GS	222
Phillip O. Richards, MD	GP	098
B. Dean Richardson		090
* David A. Richardson, MD	OBG	222
* Fred D. Richardson, MD	OM	154
* Kurt A. Richardson, MD	OTO	090
Mark M. Richardson, MD	FP	090
* Mary S. Richardson, MD	IM	106
Michael T. Richardson, MD	FP	134
* Ralph W. Richardson, MD	DR	174
* S. R. Richardson, MD	OM	102
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Gerald T. Riess, MD	N	218
George F. Rieth, MD	EM	062
Robert F. Riethmiller, MD	GP	222
* Rouchdi M. Rifai, MD	PS	174
* Patrice M. Riga, MD	DR	106
Harry L. Riggs, MD	GP	174
John L. Riker, MD	OPH	014
* Hugh K. Riley		090
Arthur L. Riley, MD	IM	034
Philip A. Riley, MD	GS	098
* Choon S. Rim, MD	N	222
Steven D. Rimar, MD	GS	174
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* Mitchell A. Rinek, MD	D	090
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* Liana G. Rinzler, MD	FP	106
Raymond J. Rion, MD	FP	014
Conchita D. Riparip, MD	PD	190
* David H. Ripper, MD	AN	070
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* Mona M. Riskalla		090
* Donna L. Ritter, MD	PD	102
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* Jan Rival, MD	IM	222
John C. Rivard, MD	AN	218
* David A. Rivera, MD	OBG	090
* Eduardo Rivera, MD	PTH	222
Emiliano N. Rivera, MD	IM	174
* Luzviminda R. Rivera, MD	IM	222
* Sara L. Rivette, MD	IM	190
Joseph Rivkin, MD	PD	174
Nasseem F. Rizkalla, MD	GS	054
Sadiq H. Rizvi, MD	IM	222
* Syed S. Rizvi, MD	OTO	022
* Joseph V. Rizzo, MD	GS	222
Paul Rizzo, MD	GS	222
William E. Rizzo, MD	IM	222
John D. Roarty, MD	OPH	222
Charles S. Robb, MD	GS	106
* Eric J. Robb, MD	AN	194
* Herbert J. Robb, MD	CDS	174
* John H. Robbert, MD	AN	106
William J. Roberson, MD	OBG	062
* Cathryn I. Roberts, MD	FP	190
* Dudley Roberts, MD	IM	222
Gary J. Roberts, MD	ORS	054
* George A. Roberts, MD	DR	222
George A. Roberts, MD	IM	106
Glen T. Roberts, MD	EM	214
* James A. Roberts, MD	OBG	218
James W. Roberts, MD	P	222
John H. Roberts, MD	IM	222
Millard S. Roberts, MD	GS	102
Robert J. Roberts, MD	OBG	106
* Warren J. Roberts, MD	ORS	054
* James W. Robertson		090
* Elmer A. Robertson, MD	PTH	026
* J. Alan Robertson, MD	GS	222
John P. Robertson, MD	PD	198
* M. Gary Robertson, MD	OBG	186
Shirley Robertson, MD	FP	090
Lawrence A. Robillard, MD	OBG	194
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James H. Robinson, MD	OBG	222
Jeffrey D. Robinson, MD	OPH	190
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* Stanley R. Robinson, MD	FP	090
Stephen W. Robinson, MD	FP	102
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Walter A. Robison, MD	GP	102
* Maurice L. Robitaille, MD	U	062
* Larry J. Robson, MD	VS	106
* Gilbert M. Roc, MD	GS	222
Ruby C. Roc, MD	IM	222
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* Jack P. Rock, MD	NS	222
Wilhelm K. Rock, MD	GP	026
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David A. Schultz, MD	R	090
Donald V. Schultz, MD	FP	222
Ernest C. Schultz, MD	R	222
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Ruben E. Siasoco, MD	IM	190
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* Mohammad R. Siddiqi, MD	GS	034
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* Gregory T. Sobczak, MD	GP	162
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Robert A. Sobel, MD	ORS	222
* Enrico C. Sobong, MD	IM	106
Joseph T. Sobota, MD	CLP	102
* Milton D. Soderberg, MD	D	134
Ralph B. Soderberg, MD	IM	222
* Robert M. Soderstrom, MD	D	062
* Chaman L. Sohal, MD	IM	222
* Young H. Sohn, MD	CD	222
Manfred H. Soiderer, MD	PTH	218
Sidney Soifer, MD	AN	222
* Melissa A. Sokol		222
* Robert J. Sokol, MD	OBG	222
William M. Sokol, MD	GS	222
Raymond A. Sokolav, MD	IM	222
* Paul B. Sokoloff, MD	AN	190
* Alfred H. Sokolowski, MD	OTO	174
* Cesario Y. Solarte, MD	IM	222
Lincoln E. Solberg, MD	OBG	222
* Gary M. Sole, MD	OPH	110
Frank J. Soler, MD	FP	222
E. G. Soleymani, MD	GP	222
Sion Soleymani, MD	GS	222
Alex E. Solik, MD	FP	062
* Francisca S. Soliven, MD	PD	222
* Abraham B. Solomon, MD	FP	222
* Allen J. Solomon, MD	R	190
* Michael H. Solomon, MD	U	218
Robert J. Solomon, MD	IM	222
* Susan J. Solomon, MD	FP	095
William Solomon, MD	IM	174
Otto P. Soltes, MD	U	222
Alan W. Solway, MD	OPH	222
* Michael E. Somand, MD	IM	222
M. Duane Sommerness, MD	P	070
* John C. Somogyi, MD	IM	222
* Benjamin Son, MD	CD	026
Rodolfo S. Son, MD	IM	222
Omer K. Sonbay, MD	IM	222
* L. Paul Sonda, MD	U	218
* Hi C. Song, MD	PM	222
Jong E. Song, MD	U	034
Anthony B. Songco, MD	GP	158
* Robert A. Songe, MD	R	222
* Matthew N. Songer, MD	ORS	134
Jaya V. Soni, MD	RO	134
Craig R. Sonke, MD	FP	154
* Ashok R. Sonnad, MD	FP	074
* James A. Sonnega, MD	CHP	218
* Victor G. Sonnino, MD	NS	154
* Gail D. Soo Hoo-Williams, MD	PM	126
Narendra K. Sood, MD	IM	222
Chai-Yakarn Soontharotoke, MD	PDA	190
Norman C. Sooy, MD	FP	170
* Steven P. Soper, MD	PTH	102
Patrick A. Sorek, MD	DR	102
Maurice G. Sorensen, MD	GP	086
* Teela Sorensen, MD	OBG	190
Daniel R. Sorenson, MD	EM	154
* Yoram Sorokin, MD	OBG	222
Marcelino C. Sorongon, MD	AN	190
Carlos M. Sosa, MD	OM	222
Freddy R. Sosa, MD	IM	174
Allen Sosin, MD	AI	174
Errol I. Soskolne, MD	PD	218
Carlos E. Sotomayor, MD	IM	062
* Ramon Souffront, MD	IM	174
* Anthony C. Southall, MD	EM	222

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** Asterisk beside name denotes AMA membership*

Southland

* Carol S. Southland, MD	FP	162
C H. Southwick, MD	GS	106
Todd C. Space, MD	DR	070
Alfred J. Spagnuolo, MD	GP	090
* Katherine Spangenberg		222
Nancy P. Spangler, MD	PD	218
* Rahima Spanta, MD	PTH	194
Robert D. Sparks, MD	IM	034
* Albert W. Sparrow, MD	PDC	090
* Ronald A. Sparschu, MD	DR	222
* Mervin J. Specht, MD	DR	054
Linda C. Speck, MD	P	174
* Lisa B. Speck, MD	IM	174
James F. Speers, MD	PH	038
Collis M. Spencer, MD	GS	034
* J. Clyde Spencer, MD	R	090
John R. Spencer, MD	GP	070
* Marshall S. Spencer, MD	CD	090
Perry C. Spencer, MD	GP	090
* William F. Spencer, MD	U	174
Dennis W. Spender, MD	IM	050
James E. Spens, MD	FP	014
* Michael Sperl, MD	R	222
* Raymond D. Sphire, MD	AN	126
* Eric Spickler, MD	DR	222
* Louis V. Spielman, MD	AN	162
* Alan V. Spigelman, MD	OPH	174
Evangeline J. Spindler, MD	PYA	218
* James R. Spindler, MD	FP	018
Adolph S. Spiro, MD	GP	222
* Henry J. Spiro, MD	OPH	174
* Mary Lou Spitz, MD	GS	174
* Werner U. Spitz, MD	PTH	222
Bertram J. Spiwak, MD	OBG	222
Earle W. Spohn, MD	GP	174
Peter J. Spohn, MD	ORS	222
* Mark T. Spoolstra, MD	IM	106
* Thomas R. Spooner, MD	OTO	106
* Thomas C. Spoor, MD	OPH	222
Josette E. Spotts, MD	GS	194
* Carolyn P. Sprague, MD	AN	174
* David S. Sprague, MD	P	098
* F. Remington Sprague, MD	IM	162
* Kevin J. Sprague, MD	ORS	222
* William E. Sprague, MD	OBG	106
John R. Spriegel, MD	IM	026
* Sherman A. Sprik, MD	OTO	106
* Dawn E. Springer, MD	FP	090
* Roland R. Springgate, MD	RHU	102
* William A. Springstead, MD	PTH	070
Carl J. Sprunk, MD	GS	222
* Robert W. Sprunk, MD	PD	070
Lakshmi Sridhar, MD	PTH	222
* B. Srinivasan, MD	AN	190
* Chander Srinivasan, MD	AN	190
* Sambamurti Srinivasan, MD	GS	150
* Samuel V. Srinivasan, MD	PM	190
Rajanee S. Sripaipan, MD	PD	082
Veera Sripinyo, MD	GS	222
* Zbigniew M. Srodulski, MD	EM	102
* Greg P. St. Claire, MD	AN	106
Lori J. Stack		222
Jack M. Stack, MD	FP	074
* John M. Stafford, MD	FP	026
* Joseph A. Stafford, MD	IM	070
* Donald L. Stageman, MD	OTO	186
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* Adelbert L. Stagg, MD	GP	214
* Gerald A. Stair, MD	IM	218
* Caren M. Stalburg		218
Benjamin B. Stamell, MD	CHP	222
Meyer Stamell, MD	FP	222
* John F. Stamler, MD	OPH	106
James D. Stamp, MD	FP	222
Laurie C. Stanczak		222
Aaron C. Stander, MD	GP	190
Stanko Stanisavljevic, MD	ORS	174
James C. Stanley, MD	GS	218
* Linda K. Stanley, MD	FP	026
* James B. Stanton, MD	ORS	126
* Theresa P. Stanton, MD	AN	222
* William J. Starbird, MD	FP	110
* Jared W. Stark, MD	PD	174
* Richard A. Stark, MD	AN	102
Morris Starkman, MD	PD	126
* Marvin L. Starman, MD	P	174
* Robert A. Starr, MD	OBG	090
* David A. Start, MD	PTH	218
Louis W. Staudt, MD	IM	222
* Wilfred B. Staufer, MD	PD	102
* Laurence E. Stawick, MD	GE	222
* Allen N. Stawis, MD	IM	126
* Marek A. Stawiski, MD	D	106
* Willard S. Stawski, MD	GS	106
Frank M. Steele, MD	IM	102
* Robert D. Steele, MD	R	174
* Robert L. Steele, MD	CD	218
William M. Steele, MD	ORS	070
Marijo Steenstra, MD	OBG	102
Charles A. Steepe, MD	PD	222
* Rudy W. Stefancik, MD	PTH	082
* Wayne K. Stefanciw, MD	U	070
* Andrew E. Stefani, MD	PS	222
Ralph S. Steffe, MD	OBG	150
* David J. Steffey, MD	R	070
Joseph C. Steffey, MD	IM	070
Harold W. Stehlik, MD	IM	222
* Edward J. Stehouwer, MD	CRS	162
* Malcolm D. Steider, MD	PD	030
* Zwi Steiger, MD	GS	222
Albert H. Stein, MD	GE	222
Hans J. Stein, MD	CRS	174
* Harvey S. Stein, MD	PD	222
* Lawrence N. Stein, MD	ORS	174
Saul C. Stein, MD	GP	222
Steven M. Stein, MD	GER	222
* Albert L. Steinbach, MD	IM	222
Barry Steinberg, MD		218
Eugene Steinberger, MD	IM	126
Starling D. Steiner, MD	OM	070
Edward E. Steinhardt, MD	U	086
Milton J. Steinhardt, MD	P	222
Charles G. Steinke, MD	GP	054
* Kevin E. Steinl		222
* Susan B. Steinman-Lininger, MD	AN	222
Edward M. Stempel, MD	PYA	174
* Mark E. Stempihar, MD	OPH	066
* Gary W. Stencel, MD	FP	126
Winton E. Stephan, MD	IM	090
Leo P. Stephens, MD	ORS	222
* Willis H. Stephens, MD	OBG	174
* Robert L. Stephenson, MD	OPH	174
* Wesley F. Stephenson, MD	GP	046
Edward T. Stern, MD	AI	106
Leonard H. Stern, MD	GP	222
* Sheldon D. Stern, MD	OPH	174
* William K. Stetson, MD	FP	062
Georgine M. Steude, MD	AN	218
Charles E. Stevens, MD	FP	094
Mark C. Stevens, MD	FP	134
Philip K. Stevens, MD	GS	062
Raymond Stevens, MD	IM	174
* Todd C. Stevens, MD	IM	106
Tommy S. Stevens, MD	FP	062
* John E. Stevenson, MD	NS	106
* Paul H. Stevenson, MD	AN	102
* Peter L. Stevenson, MD	OBG	222
Robert F. Stevenson, MD	OPH	042
Hyun A. Steward, MD	FP	158
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* Daniel P. Stewart, MD	EM	102
* Duncan E. Stewart, MD	R	034
* F. James Stewart, MD	FP	170
* James R. Stewart, MD	CD	174
* Landis C. Stewart, MD	OPH	114
* Lewis L. Stewart, MD	IM	098
* Mark C. Stewart, MD	ORS	022
Robert B. Stewart, MD	AN	102
Robert M. Stewart, MD	OBG	222
Sharon M. Stewart, MD	OM	090
* William K. Stewart, MD	GP	030
* Judith E. Steyer, MD	FP	134
* Henry B. Stibitz, MD	IM	014
* Lawrence D. Stieglitz, MD	P	102
* Craig G. Stien, MD	OTO	134
Edward W. Stilwill, MD	DR	070
George D. Stilwill, MD	ORS	090
* Paul R. Stimson, MD	P	090
* Donald J. Stinar, MD	IM	034
* Harold N. Stinson, MD	AN	106
* Gerald S. Stipanuk, MD	IM	058
* Mack C. Stirling, MD	CDS	070
Dwight E. Stith, MD	GP	222
Robert H. Stobbelaar, MD	GS	186
* Thomas B. Stock, MD	CD	222
Lawrence L. Stocker, MD	OPH	222
* Sharon L. Stocking, MD	DR	062
Fred S. Stockinger, MD	CD	106

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* Alan G. Stoddard, MD	AN	102
* James F. Stoddard, MD	OTO	022
* Sheldon S. Stoffer, MD	IM	174
G. Edward Stokes, MD	GS	070
Carl A. Stolberg, MD	ORS	098
* Robert L. Stoler, MD	IM	218
Raymond Stoller, MD	GS	222
A. Kenneth Stolpman, MD	OBG	174
* Jon L. Stolte, MD	GS	174
* Allen J. Stone, MD	R	222
* Benjamin J. Stone, MD	A	090
* Charles H. Stone, MD	GS	022
* David Q. Stone, MD	OM	222
* Ethon L. Stone, MD	PD	098
* John M. Stone, MD	IM	222
* Julius Stone, MD	D	126
* Kevin T. Stone, MD	GS	174
* Richard A. Stone, MD	D	126
* Sidney L. Stone, MD	OPH	222
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Dolores B. Storey		162
* Phillip B. Storm, MD	U	090
* Phillip B. Stott, MD	ON	102
* Randall C. Stout, MD	OPH	034
Robert M. Stow, MD	IM	090
Charles G. Stoyka, MD	IM	222
David A. Strahle, MD	DR	062
* David J. Straight, MD	IM	070
Richard E. Straith, MD	PS	174
Charles R. Strancke, MD	EM	134
* Vernon F. Strand, MD	GS	026
John F. Strandmark, MD	IM	090
* Ruth H. Strang, MD	PD	218
* Stanley R. Strasius, MD	IM	218
Donald P. Stratton, MD	R	162
John W. Strayer, MD	GS	026
* Christopher H. Strayhorn, MD	IM	026
Marcy L. Street, MD	D	090
* Robert G. Streicher, MD	GP	158
* Bernard J. Stremler, MD	AN	174
Walter F. Strempek, MD	PH	090
Jeff Strickler		090
* Marc L. Strickler, MD	PM	218
Anton Strocel, MD	OBG	062
* Livius N. Stroia, MD	U	022
Arthur W. Strom, MD	IM	078
Douglas D. Strong, MD	OTO	222
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* James P. Strong, MD	FP	182
* Leroy E. Strong, MD	OPH	106
Jeoffrey K. Stross, MD	IM	218
* James D. Stroud, MD	D	174
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* Gloria M. Strutz, MD	EM	126
* Curtis D. Struyk, MD	OBG	106
* Joan C. Stryker, MD	OBS	222
Walter A. Stryker, MD	PTH	222
F. James Stubbart, MD	D	162
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Samuel S. Stubbs, MD	PD	102
Roscoe V. Stuber, MD	GS	118
* Ronald L. Stuk, MD	R	162
Elizabeth A. Stumbo, MD	PD	218
John H. Stunz, MD	PM	174
* Stephen A. Stuppler, MD	U	126
* Amadeo R. Sturla, MD	IM	222
* Cesar A. Sturla, MD	IM	222
* Randall H. Sturm, MD	ID	062
* Robert H. Sturman, MD	NS	222
* Stephen W. Sturman, MD	D	174
L. Lamar Styer, MD	FP	186
Ernesto L. Suarez, MD	CDS	102
A. L. Suarez-Martinez, MD	ORS	222
Gali V. Subbareddy, MD	GS	062
J. A. Subczynski, MD	NS	222
* Mythili Subramanian, MD	OBG	062
* Sarada Subramanian, MD	DR	118
* Mayer Subrin, MD	P	222
Bashar Succar, MD	OTO	174
* John R. Suchomel, MD	OPH	174
Doris A. Suciu, MD	IM	062
* Parul S. Sud, MD	IM	062
* Leonard B. Sudakin, MD	OBG	222
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Irene Suen-Yip, MD	OM	222
* Alan Sugar, MD	OPH	218
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* George T. Sugiyama, MD	CDS	106
* Jung K. Suhr, MD	IM	190
Leif G. Suhrland, MD	HEM	090
Pramote Sujarit, MD	AN	222
Adolph W. Suksta, MD	FP	126
* Dorai K. Sukumaran, MD	TS	222
* K. P. Sukumaran, MD	AN	190
* Yi C. Sul, MD	N	222
Hugh L. Sulfridge, MD	ORS	190
Andrew J. Sulich, MD	IM	062
* Cheryl A. Sulisz, MD	OM	154
* Glen D. Sullenger, MD	OPH	062
John C. Sullivan, MD	OTO	194
Michael G. Sullivan, MD	OPH	096
Paul J. Sullivan, MD	PD	222
Paul M. Sullivan, MD	IM	174
* Thomas M. Sullivan, MD	P	222
* Walter G. Sullivan, MD	PS	222
* Marilyn G. Sultana, MD	OPH	222
L. Carl Sultzman, MD	ORS	222
Bernard T. Sumcad, MD	U	222
Timur Sumer, MD	FP	062
Denwit Sumetanon, MD	IM	222
* Mike H. Summerer, MD	CD	102
Keh-Ming Sun, MD	PTH	106
* Bilugali M. Sundara, MD	PD	022
* Alistair S. Sundareson, MD	PTH	222
Edwin C. Sundell, MD	IM	090
* James C. Sunstrum, MD	IM	222
* Barbara Ann Supanich, MD	FP	150
* Preecha Supanwanid, MD	PS	090
* Elizabeth M. Supina		222
* Komol Surakomol, MD	IM	222
* Pongchayut Surapipith, MD	GS	062
Eric S. Suris		126
Gerard K. Surmann, MD	DR	174
* James A. Surrell, MD	CRS	106
* Leela Suruli, MD	OBG	222
Kirk L. Susott, MD	U	054
* Kathryn H. Sussman, MD	D	126
* Bharat B. Sutariya		222
* William F. Sutter, MD	GP	138
* David B. Sutton, MD	PD	162
Marion D. Sutton, MD	FP	154
* Raymond L. Sutton, MD	GP	095
Raymond H. Suwinski, MD	GP	222
* Masamichi Suzuki, MD	OBG	126
William G. Swagman, MD	AN	106
* L. N. Swamy, MD	CD	134
* Jerome W. Swan, MD	OPH	106
Lionel F. Swan, MD	GP	222
Raymond O. Swann, MD	OBG	102
* Alfred B. Swanson, MD	ORS	106
* Genevieve D. Swanson, MD	PS	106
* Steven E. Swanson, MD	NS	218
* Har Swarup, MD	GS	094
* David A. Swastek, MD	AN	218
Bernard J. Sweeney, MD	IM	070
* Lawrence C. Sweet, MD	A	174
Harold C. Swenson, MD	A	106
Leland L. Swenson, MD	ORS	162
* James J. Swetech, MD	IM	222
* Michael A. Swirtz		222
* Paula K. Swisher		222
Scott N. Swisher, MD	IM	090
* James M. Switzer, MD	R	222
Richard A. Switzer, MD	PD	106
Jainullabdin Syed, MD	P	022
* Mahmud U. Syed, MD	IM	174
Muhammad H. Syed, MD	P	154
Jonathan P. Sykes, MD	U	218
* Mary Sue Sylwestrzak, MD	PD	174
* Marta R. Szego-Koltay, MD	R	095
* Leslie S. Szeles, MD	OTO	102
* Susanna Szelestey, MD	OBG	174
* Eric J. Szilagy, MD	GS	222
D. Emerick Szilagyi, MD	CD	222
Stanley J. Szwalek, MD	NEP	070
Dennis C. Szymanski, MD	NS	026
Margaret A. Szymanski, MD	OBG	126
Michael L. Szymanski, MD	FP	218

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Senen C. Tabangay, MD	AN	222
* Toufik Tabbara, MD	GS	218
* Romeo H. Tabbilos, MD	OBG	222
Rodman E. Taber, MD	TS	222
* Rodman M. Taber, MD	OBG	106
* James D. Taborn, MD	IM	102
* Blane L. Tacia, MD	GS	098
* David F. Tague, MD	DR	102
Zia E. Taheri, MD	NS	022
Meena Tahilramani, MD	PD	190
* Saleem A. Tahir, MD	N	222
* Bing T. Tai, MD	DR	090
* Joseph R. Tai, MD	IM	098
Syed S. Taj, MD	IM	222
* Mark Takagishi, MD	PD	090
Gerald M. Takala, MD	FP	182
* Akemi Takekoshi, MD	N	126
* Mones Takriti, MD	IM	174
* Walter J. Talamonti, MD	IM	222
Joe G. Talbert, MD	TS	222
Frank G. Talbot, MD	OM	222
* Joseph E. Talbot, MD	R	190
* Kathryn W. Talbot, MD	PD	174
* Lawrence G. Talbot, MD	OPH	174
J. D. Talbott, DO	GS	090
* Timothy M. Talbott, MD	CRS	106
Ghalib Y. Talia, MD	GS	174
Sarveswararao Talla, MD	PD	222
Robert W. Talley, MD	IM	222
* Jonathan C. Tallman		090
Frederick N. Talmers, MD	CD	222
Janet L. Talmo, MD	FP	106
* Samuel E. Talsma, MD	AN	218
Paul K. Tam, MD	PTH	026
Martin S. Tamler, MD	PM	174
* Usha R. Tampi, MD	IM	158
* Ben G. Tan, MD	OPH	222
Jaime F. Tan, MD	GP	086
* Thian Lai Tan, MD	IM	174
* Antoinette Tanay, MD	D	174
* Emanuel Tanay, MD	P	222
* Violeta Tanfranca, MD	PD	126
* Gene D. Tang, MD	CLP	070
Penput Tangsintanapas, MD	IM	190
C. Y. Tanhehco, MD	PD	222
Dalmacio L. Tanhehco, MD	IM	222
Pacita L. Tanhehco, MD	PD	062
Natalia M. Tanner, MD	PD	222
* Russell E. Tanner, MD	OBG	095
* Hernani S. Tansuche, MD	DR	194
* John H. Tanton, MD	OPH	170
* Efstathios Tapazoglou, MD	IM	222
Nael M. Tarakji, MD	N	062
Steven G. Tarangle, MD	GP	034
* James A. Taren, MD	NS	218
* Irmina Targowski, MD	FP	102
Dick A. Tarpinian, MD	IM	174
* Harry Tarpinian, MD	OBG	222
* Edward A. Tashjian, MD	PM	174
Terrence W. Tatarchuk, MD	GS	226
Philip W. Tate, MD	IM	106
Maurice Tatelman, MD	R	222
Kam R. Tatineni, MD	P	034
* Wayne A. Taulbee, MD	OPH	206
William H. Taurence, MD	GP	222
* John W. Tauscher, MD	PD	062
Arun Tavee, MD	U	222
* Robert Tawil, MD	AN	174
* Nabil T. Tawile, MD	GE	222
* Michael K. Tay, MD	RO	106
* Amos Taylor, MD	GP	222
* Charles I. Taylor, MD	END	174
* Donald M. Taylor, MD	OBG	174
Douglas H. Taylor, MD	GP	026
Glenn E. Taylor, MD	FP	174
James A. Taylor, DO	FP	098
* Joseph L. Taylor, MD	PD	106
* K. Leslie Taylor, MD	AN	014
* Kevin M. Taylor, MD	IM	218
Michael G. Taylor, MD	IM	222
Miles Taylor, MD	OTO	222
Nelson M. Taylor, MD	IM	222
* Richard A. Taylor, MD	N	222
Richard L. Taylor, MD	R	114
Robert E. Taylor, MD	AN	190
* Ronald S. Taylor, MD	PM	174
* Susan J. Taylor, MD	OBG	106
* Walter C. Taylor, MD	FP	222
William B. Taylor, MD	DMP	218
William E. Taylor, MD	EM	218
Myron A. Tazelaar, MD	GP	034
Henry A. Tazzioli, MD	GP	222
Soledad C. Te, MD	DR	202
* Thomas M. Teal, MD	FP	206
* Kurt E. Tech, MD	DR	222
Sivareddy Tegulapalle, MD	IM	034
* Robert A. Teitge, MD	ORS	222
Manhar J. Tejura, MD	CD	158
James L. Telfer, MD	ORS	218
* Steven A. Telian, MD	OTO	218
* Madan M. Telikicherla, MD	PM	222
* Manjula Tella, MD	N	026
Henry C. Tellman, MD	U	162
Randall J. Telman, MD	PS	106
* Allen J. Telmos, MD	GS	222
John E. Temple, MD	R	174
Ralph Ten Have, MD	GP	106
Henry W. Ten Pas, MD	AN	186
John H. Ten Pas, MD	ORS	186
Thomas A. Tenaglia, MD	FP	222
Emmanuel M. Tendero, MD	P	106
Steven D. Tennenberg, MD	GS	222
Sima Teodorovic, MD	OBG	218
Stephen G. Tepastte, MD	FP	090
* Nicholas A. Tepe, MD	CDS	174
* Dhiti Tepkasetkul, MD	GS	082
Donald H. Ter Keurst, MD	PD	106
Gregory H. Teraikian, DO	AN	194
Howard R. Terebelo, DO	IM	222
Margaret S. Terpenning, MD	IM	218
* Travis D. Terrell, MD	OBG	174
James C. Terrian, MD	GPM	042
* Barbara C. Tess, MD	FP	126
Allen N. Tesser, MD	D	174
* Martin E. Tessler, MD	D	174
Manuel L. Teves, MD	GS	086
* Kenneth M. Tewel, MD	OPH	138
Carolyn M. Texera, MD	PTH	090
* Donald W. Thaden, MD	PD	090
* Maran Thamilarasan		218
* B. M. Thangamani, MD	IM	094
Phan H. Thanh, MD	GS	174
* Krishna Thavarajah, MD	IM	222
* Gary J. Theisen, MD	AN	102
Paul G. Theodore, MD	OBG	106
Anna M. Theodoulou, MD	PTH	222
* Glafkos H. Theodoulou, MD	ORS	222
Kriangsak Thepveera, MD	IM	190
* Richard P. Thiede, MD	IM	090
* Scott A. Thiele, MD	OBG	154
E. Thurston Thieme, MD	GS	218
* Robert F. Thimmig, MD	GS	090
Richard L. Thirlby, MD	U	070
Steven J. Thiry, MD	FP	218
Timothy K. Thoits, MD	N	106
Anil K. Thomas, MD	IM	126
* Geoffrey M. Thomas, MD	NS	218
Gerald B. Thomas, MD	IM	190
* Jean B. Thomas, MD	FP	106
* L. Murray Thomas, MD	NS	222
* Lorna L. Thomas, MD	D	222
M. Varkey Thomas, MD	PUD	062
Philomina C. Thomas, MD	PD	222
* Thomas K. Thomas, MD	FP	222
William G. Thomas, MD	FP	070
Arthur L. Thompson, MD	PD	222
* Charles A. Thompson, MD	IM	062
D. Eugene Thompson, MD	ORS	174
* David E. Thompson, MD	U	106
Edward C. Thompson, MD	AN	106
Frank D. Thompson, MD	AN	106
Hugh O. Thompson, MD	GP	222
Jack W. Thompson, MD	OBG	062
Margaret E. Thompson, MD	FP	106
* Michael D. Thompson, MD	EM	218
* Norman W. Thompson, MD	GS	218
* William C. Thompson, MD	DR	222
William E. Thompson, MD	PS	062
Karen N. Thompson-Cardwell, MD	IM	222
* Peter S. Thoms, MD	FP	062
* Susan S. Thoms, MD	OPH	174
David L. Thomson, MD	END	126
* Allan K. Thorburn, MD	P	174
* Mary E. Thorne, MD	FP	090
Kenneth E. Thorp, MD	R	090
* Donna Thorpe		222
David C. Thorrez, MD	PD	218
* Surya R. Thota, MD	AN	062
* Barbara A. Threatt, MD	DR	218

Compared With Critical Care America's STAR Commitment, Everything Else Is Just A Leap Of Faith



Critical Care America, an innovative leader in home infusion therapy, is dedicated to providing superior quality care and support to patients in their homes. Our reputation for responsiveness to our customers needs has made Critical Care America a leader in home infusion therapy.

The S.T.A.R. (Specially Tailored Action and Results) Commitment carries our guarantee that we will listen to you, work with you and provide you with:

- ★ realistic, workable solutions to meet your home care patient challenges;
- ★ streamlined processes to make your experience with Critical Care America simpler and more efficient;
- ★ innovative, creative options that enhance your ability to successfully manage the needs of home infusion patients; and,
- ★ tangible results that ensure your ultimate satisfaction with Critical Care America's services.

Critical Care America recognizes your needs, and has the resources and commitment to quickly respond to them. We are committed to developing programs that give you exactly what you need, when you need it. And will then back that commitment in writing.

So before you leap into an arrangement with any other home infusion therapy provider, find out more about our STAR Commitment and how it will benefit you. Just call your local Michigan Critical Care America representative to get things started. We know you will be satisfied with our actions—and the results.

Responsiveness Is Where We Shine™ ★

Critical Care
AMERICA

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313-373-3131 ★ 800-333-2133

Alphabetical Listing of MSMS Members

** Asterisk beside name denotes AMA membership*

Robert C. Thumann, MD	U	222
Sadie Thumim, MD	GP	222
* Richard Thurmer, DO	FP	102
Jalal J. Thwainey, MD	GS	222
* V. S. Thyagarajan, MD	IM	098
* Dennis M. Tibble, MD	OPH	190
Angela R. Tiberio, MD	IM	106
Ralph J. Tidalgo, MD	IM	222
* Robert L. Tiel, MD	NS	222
* Myles E. Tieszen, MD	GS	190
* Barbara Tilben, DO	FP	206
Martha A. Tillson, MD	PTH	146
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* Hilary H. Timmis, MD	TS	174
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Timothy J. Tinetti, MD	IM	174
Sik W. Ting, MD	AN	222
Yoeh M. Ting, MD	R	174
Roderic E. Tinney, MD	PD	170
Rebecca P. Tisch, MD	OPH	218
James H. Tisdel, MD	OBG	194
Garson H. Tishkoff, MD	IM	090
* Joseph J. Tiziani, MD	P	190
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* Rodrigo R. Tobar, MD	FP	222
* James F. Tobin, MD	OBG	134
* Patrick J. Tobin, MD	D	070
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* W. Mark Todd, MD	N	102
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* Luis A. Tomatis, MD	TS	106
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* George K. Tong, MD	PTH	190
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Donald G. Trapp, MD	GP	078
* Richard S. Traul, MD	AN	102
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* Gaylord A. Treadway, MD	FP	022
* Marjorie C. Treadwell, MD	OBG	222
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* John H. Triebwasser, MD	IM	222
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* Daniel Triezenberg, MD	FP	142
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* Wayne M. Trinklein, MD	FP	090
Lucius C. Tripp, MD	NS	222
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* Dushyant Trivedi, MD	P	218
* John N. Trobaugh, MD	AN	022
* Jonathan D. Trobe, MD	OPH	218
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Richard M. Trosch, MD	N	222
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* Mark G. Trudell, MD	FP	062
* Thomas J. Trueheart, MD	PD	222
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Jawahar L. Tummala, MD	PD	062
Madhusudana R. Tummala, MD	DR	062
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* Robert L. Tupper, MD	IM	106
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* Gustav A. Uhlich, MD	GE	170
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* R. D. Untalan, MD	GS	054
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* Catherine A. Upton, MD	IM	174
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* Eva A. Urban, MD	OPH	090
Robert J. Urban, MD	FP	204
* William R. Urbancic, MD	GP	126
Robert C. Urbanic, MD	IM	218
* Stephen A. Urbin, MD	ORS	186
Vernon C. Urich, MD	U	062
Maurice D. Urist, MD	OPH	026
* Ilija Urosev, MD	IM	222
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* Vernon D. Vaandrager, MD	PD	106
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Gita N. Vaidya, MD	IM	050
Ramesh K. Vaidya, MD	U	222
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* Vinod R. Vakhariya, MD	OBG	222
* Jose C. Valderrama, MD	OBG	218
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* Paul N. Valenstein, MD	PTH	218
Patricia V. Valia, MD	PD	190
Samuel S. Valia, MD	PS	190
* Krishna D. Valjee, MD	GS	194
Jose M. Valle, MD	IM	034
Dennis E. Van Alst, MD	FP	226
Fred J. Van Alstine, MD	FP	206
* Carl Van Appledorn, MD	U	218
* Gerald G. Van Arendonk, MD	FP	102
Joseph P. Van Ark, MD	FP	090
William L. Van Arsdale, MD	GS	034
Edward W. Van Auken, MD	GP	142
L. A. Van Becelaere, MD	OBG	222
* D. B. Van Brocklin, MD	OM	062
James D. Van Brocklin, MD	PM	062
Bruce L. Van Cleave, MD	FP	174
Fred W. Van Dahm, MD	PD	106
John C. Van Dalson, MD	FP	070
Forrest R. Van Dam, MD	P	106
* Peter S. Van De Mark, MD	IM	142
Jerrian Van Dellen, MD	GP	170
* Hendrik C. Van Den Ende, MD	FP	134
* Frank G. Van Deventer, MD	P	222
* Glenn M. Van Dommelen, MD	OBG	106
* Thomas H. Van Doren, MD	P	102
* Frederick W. Van Duyne, MD	FP	062
David H. Van Dyke, MD	N	106
Richard A. Van Dyken, MD	IM	106
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* Timothy Van Every, MD	OPH	170
Leonard W. Van Gelder, MD	EM	186
* Jeffrey T. Van Gelderen, MD	PD	022
* Kornelius Van Goor, MD	D	106
Donald E. Van Hoek, MD	GS	222
Russell N. Van Houzen, MD	IM	070

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* Carl E. Van Krimpen, MD	IM	186
Jerry E. Van Kuiken, MD	PD	186
Philip L. Van Lente, MD	FP	106
Glenn R. Van Noord, MD	FP	106
* Cornelius Van Nuis, MD	N	106
* Howard E. Van Oosten, MD	GP	150
Peter G. Van Oosten, MD	OBG	102
Keith Van Oosterhout, MD	FP	026
Marinus Van Ooyen, MD	DR	114
* Gordon F. Van Otteren, MD	IM	106
Paul Van Portfliet, MD	OPH	106
Leonard F. Van Raaphorst, MD	GS	222
* Frederik S. Van Reesema, MD	IM	218
* Richard M. Van Schoick, MD	PD	098
* Timothy S. Van Schoick, MD	PD	098
* Robert L. Van Sickle, MD	PD	154
Ellis J. Van Slyck, MD	IM	222
* John R. Van Timmeren, MD	AN	106
* A. Robert Van Tuinen, MD	IM	106
* Ronald J. Van Valkenburg, MD	CHP	034
* Peter D. Van Vliet, MD	PTH	106
* Ada E. Van Vloten, MD	PD	206
Fredk I. Van Wagnen, MD	FP	098
Lynn C. Van Wagnen, MD	IM	098
* Gerard L. Van Wesep, MD	OPH	106
Gerald E. Van Wieren, MD	IM	166
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* David A. Van Winkle, MD	FP	162
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* Corwin G. VanDerVeer, MD	OBG	106
* Permporn Vanasupa, MD	GS	194
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Gary R. Vandekerckhove, MD	IM	070
R. J. Vanden Belt, MD	CD	218
Kenneth Vanden Berg, MD	GS	174
* Peter M. Vanden Berg, MD	GS	186
* R. J. Vanden Berg, MD	IM	186
Tunis Vanden Berg, MD	FP	106
William O. Vanden Berg, MD	OBG	106
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* Susan N. VandenBerg, MD	EM	106
* W. Christian VandenBerg, MD	PM	106
William VandenBerg, MD	OPH	106
* William J. Vandenbelt, MD	OBG	022
A. R. Vandenberg, MD	IM	106
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* Paul L. Vandenbrink, MD	U	102
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* Scott D. Vander Hill, MD	FP	142
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* Kenneth J. Vander Kolk, MD	OBG	106
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Raymond L. Vander Meer, MD	IM	106
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* Ronald L. Vander Molen, MD	GS	174
Philip B. Vander Naald, MD	AN	170
* Larry M. Vander Plas, MD	OPH	034
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* Ronald L. VanderLugt, MD	OPH	102
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* Siavosh Varjavandi, MD	U	062
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* Virgilio F. Vasquez, MD	N	162
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* Jerold P. Veldman, MD	PD	030
Mauro B. Velilla, MD	GP	222
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John H. Vincent, MD	GP	190
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* F. V. Viola, MD	OM	222
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* Jack B. Wagoner, MD	AN	098
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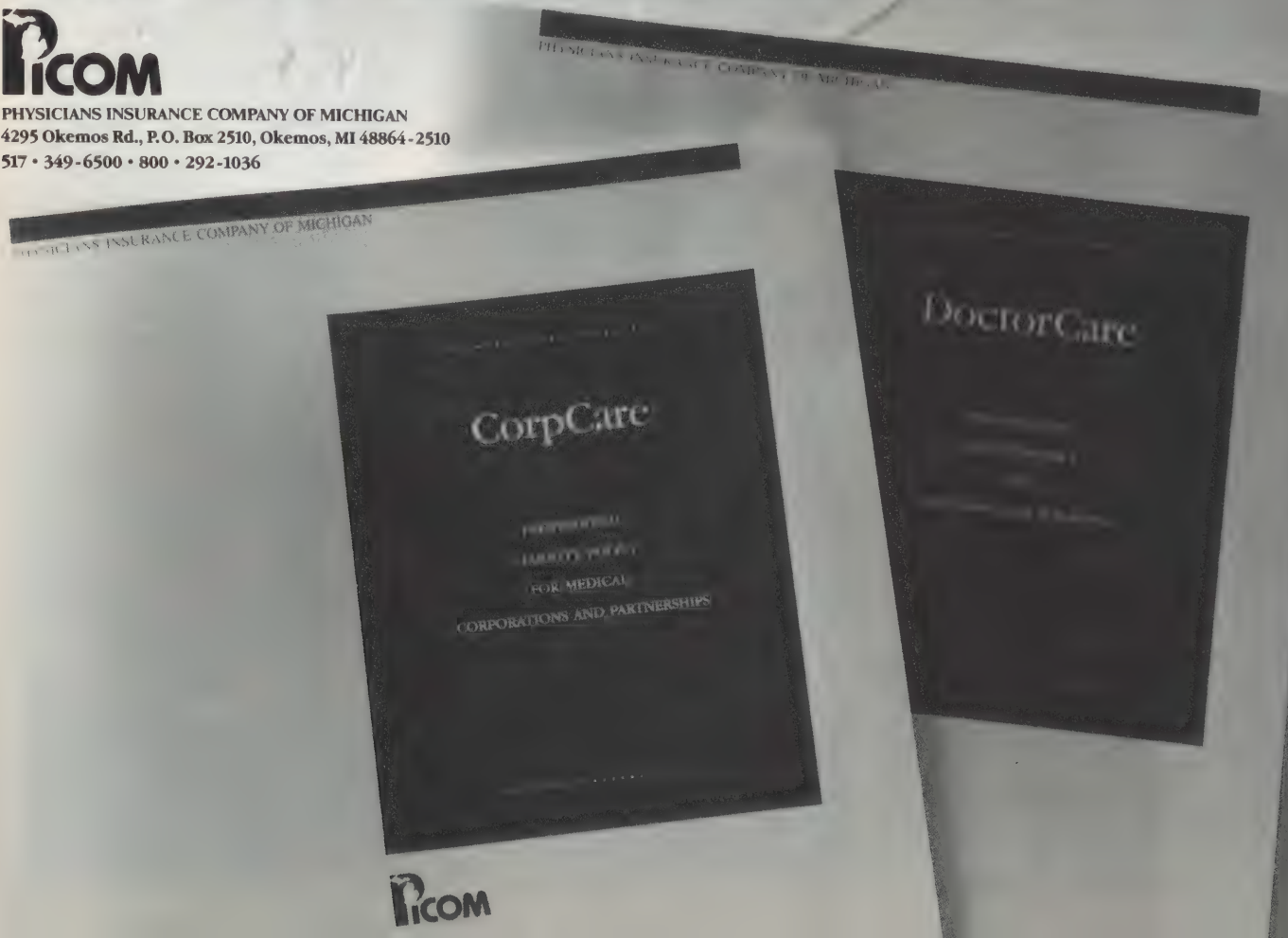
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A – Allergy

SPECIALTY – A

Edward Alpert, MD	126
William Appel, MD	102
Emily W. Bandera, MD	218
* Peter P. Barlow, MD	174
* James T. Bishop, MD	070
* Douglas H. Blanks, MD	222
J. Daniel Clifford, MD	098
Leonard L. Di Lella, MD	222
Alex S. Friedlaender, MD	174
* Leonard S. Gell, MD	106
* Rasem D. Ghannam, MD	090
Ben L. Gold, MD	218
* Jack E. Goodwin, MD	190
Frank S. Greenslit, MD	222
Benjamin R. Gutow, MD	222
Hilda M. Hensel, MD	158
* Martin E. Hurwitz, MD	218
Salah Itani, MD	222
* Lawrence E. Lee, MD	126
* John M. Lesesne, MD	222
* C. Maternowski, MD	106
Kenneth P. Mathews, MD	218
* James D. Mc Cullough, MD	174
* James L. Mc Donald, MD	102
James A. Mc Lean, MD	218
* Myrna R. Meneses, MD	134
* Kanwal Mohan, MD	090
* Frank A. Munden, MD	186
* S. William Paris, MD	174
* Lawrence I. Pasik, MD	174
Harinath Pillalamarri, MD	090
Arnold M. Podolsky, MD	174
Paul D. Radgens, MD	222
* Evan J. Reinders, MD	162
* Allan I. Salomon, MD	174
Ernst O. Schreiber, MD	062
* Leonard Schreier, MD	174
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* Timothy A. Smith, MD	190
* Benjamin J. Stone, MD	090
* Lawrence C. Sweet, MD	174
Harold C. Swenson, MD	106
Israel Wiener, MD	222
* B. David Wilson, MD	102

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Guillermo P. Cabrera, MD	174
Ray W. Chamberlain, MD	096
Avison Gano, MD	214
* Robert C. Monson, MD	222

SPECIALTY – ADL

Irene S. Danek, MD	070

SPECIALTY – AI

Diane L. Baranowski, MD	222
* James C. Breneman, MD	102
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* Satish K. Gupta, MD	090
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David L. Hammer, MD	106
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* Cesar V. Alcid, MD	062
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* Pratap K. Aravapalli, MD	062
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* David K. Austin, MD	074
Shirley Austin, MD	222
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* Gerald Berlin, DO	106
Charles J. Berman, MD	174
Kenneth J. Betten, MD	102
Hans A. Beyer, MD	174
Bert M. Bez, DO	090
Kumbla P. Bhakta, MD	062
* Bharathi I. Bhat, MD	026
Mark J. Bielaczyc, MD	170
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Wilbur R. Birk, MD	102
Eugene E. Bleil, MD	090
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* Donald W. Brown, DO	162
* Eli M. Brown, MD	222
* Mark R. Bruni, MD	174
* Garry J. Bundy, MD	022
Raymond C. Bush, MD	154
Mary Lou Byrd, MD	106
John G. Calwell, MD	222
Marcelo C. Canlas, MD	034
* Mary E. Cantrell, MD	222
* Napoleon N. Capili, MD	222
William M. Capina, MD	190
* Roque L. Carbajo, MD	222
Samuel H. Carter, MD	218
Douglas H. Castleman, MD	018
* Albert J. Ceravolo, MD	222
Mahmoud Chafty, MD	194
* Michael D. Chafty, MD	106
T. Chairatana, MD	222
Wayne A. Chambers, MD	222
* Suk J. Chang, MD	090
Christopher C. Chaput, MD	174
* Kathleen E. Chase, MD	106

AN – Anesthesiology

* George J. Chatas, MD	218
* John W. Chatas, MD	218
* Young H. Chi, MD	126
Young H. Chi, MD	090
* Antonio M. Chiasson, MD	162
* Elie J. Chidiac, MD	222
* Kyn Hong Cho, MD	222
Don S. Choe, MD	026
Byong-Du Choi, MD	090
* Yung S. Choi, MD	026
* Yong S. Chung, MD	062
* Jeffrey K. Clark, MD	222
* Mark D. Clark, MD	102
Harriet A. Clarke, MD	174
* William E. Clay, MD	126
Parish B. Cleveland, MD	222
* Robert G. Cline, MD	070
* Larry M. Cole, DO	022
John F. Coleman, MD	070
* Beverly A. Collier, MD	090
Hubert V. Collins, MD	034
James U. Collins, MD	106
Edward D. Conner, MD	114
Franklin T. Cookinham, MD	222
* Robert J. Coombs, DO	014
* Thomas H. Corbett, MD	218
* Jon P. Cowan, MD	106
* William D. Cowan, MD	162
* Nicholas Csonka, MD	022
* Sergio Q. Cuison, MD	162
* James C. Culver, MD	062
* Michael J. Curtin, MD	050
* Diane M. Czuk-Smith, MD	222
* Alan A. D'Augustine, DO	222
* David A. Danley, MD	222
* Thomas E. Daufenbach, MD	102
* Fred N. Davis, MD	106
* Thomas B. Davis, MD	106
* Vincent R. De Las Alas, MD	218
Thomas J. DeKornfeld, MD	218
Thomas E. Del Giorno, MD	096
* Peter A. Del Giudice, MD	222
George T. Demian, MD	222
E. D. Deocampo, MD	126
* Kuldip S. Deogun, MD	174
Hemant D. Desai, MD	062
Piyush K. Desai, MD	222
Prakash R. Dhadphale, MD	134
Raniero Di Piero, MD	222
Richard S. Dillman, MD	218
* Khalil Dirani, MD	222
* Dennis W. Dobritt, DO	174
James F. Doebele, MD	090
* Marc K. Domsky, MD	222
Michael J. Dorsey, MD	218
* Bret H. Doud, MD	106
Zofia J. Drozdowska, MD	222
* Gary M. Druskovich, MD	102
* Frank S. Du Pont, MD	222
* Vincent J. Dube, MD	096
* David L. Dull, MD	106
Paul R. Dumke, MD	222
* M. Tim Dunfee, MD	102
* Bryan J. Dunlop, MD	102
* Jean-Paul J. Dupuis, MD	194
* Theodore E. Dushane, MD	218
* Gregory D. Dwight, DO	222
Richard L. Ellison, MD	154
* Gerhard C. Endler, MD	222
Ann M. Ernst, DO	194
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John D. Everett, MD	090
Alena Fabian, MD	090
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* Paul J. Fatum, MD	106
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* Jonathon R. Fiebing, MD	070
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* R. Michael Flores, MD	222
* William J. A. Ford, MD	206
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Alphabetical Listing of MSMS Members by Specialty

** Asterisk beside name denotes AMA membership*

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* Richard P. Gallucci, MD	222
* Navora Gapas-Cuison, MD	162
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Frank Lee, MD	222
K C. Lee, MD	090
Wanda Y. Lee, MD	090
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Ariston C. Sandoval, MD	126
* Jon A. Santiago, MD	062
William A. Sautter, MD	098
Joseph S. Sazyc, MD	222
Heinrich C. Schaefer, MD	222
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Matthew M. Shankle, MD	062
* Gholamreza Shareghi, MD	026
Hyun W. Shin, MD	190

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* Richard Y. Shin, MD	222
* Daniel L. Silvasi, MD	218
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David F. Simpson, MD	222
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* Louis V. Spielman, MD	162
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* B. Srinivasan, MD	190
* Chander Srinivasan, MD	190
* Greg P. St. Claire, MD	090
* Theresa P. Stanton, MD	222
* Richard A. Stark, MD	102
* Susan B. Steinman-Lininger, MD	222
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* Leonel M. Torres, MD	222
Neal R. Touran, MD	170
* Karen B. Traber, MD	218
* Richard S. Traul, MD	102
* John H. Traylor, MD	174
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* Ching S. Tsay, MD	030
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* Marc J. Tuchman, MD	218
* Myrna C. Tumacder, MD	206
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* Jerrold G. Utsler, MD	218
* Vidyachandra Vakhariya, MD	222
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* John R. Van Timmeren, MD	106
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SPECIALTY – AS

* Daniel J. Benishek, MD	054

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Qazi S. Azher, MD	062
James F. Clark, MD	130
* John D. Crissman, MD	222
Pradeep P. Dhital, MD	222
David M. Graham, MD	106
David E. Sharp, MD	106

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* Morris Brown, MD	222
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Scott H. Adelman, MD	090
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CD – Cardiovascular Diseases

* James P. Gallagher, MD	222
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I. Enrique Romero, MD	222
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Theodore L. Schreiber, MD	174
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Delano R. Small, MD	174
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* Marshall S. Spencer, MD	090
* Robert L. Steele, MD	218
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* Thomas B. Stock, MD	222
Fred S. Stockinger, MD	106
* Mike H. Summerer, MD	102
* L. N. Swamy, MD	134
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* Vincent J. Turcotte, MD	106
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* Stanley B. Wolfe, MD	222
* Paul M. Zack, MD	090
* Edward J. Zaleski, MD	222
* S. B. Zampani, MD	222
Mark L. Zande, MD	098
* Allen E. Zencka, MD	026
* Lawrence J. Zgliniec, MD	174
Eldred G. Zobl, MD	174

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* Elie D. Aboulafia, MD	222
* Richard A. Berg, MD	222
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O. William Brown, MD	222
Forest D. Dodrill, MD	222
* Daniel H. Drake, MD	070
* Joseph P. Elliott, MD	222
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* Marcia S. Fowler, MD	222
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* Syed S. Hossain, MD	194
* Lynn E. Howell, MD	174
* Allan L. Ippolito, MD	062
Krishna M. Jain, MD	102
Douglas H. Joyce, DO	102
* Jia Y. Jung, MD	090
* Jorge O. Just, MD	174
* Ali Kafi, MD	222
* Mohammad M. Khaghany, MD	102

CHP –. Child Psychiatry

* Wayne K. Kinning, MD	062
Frederick H. Levine, MD	222
* William G. Liekweg, MD	062
* Curtis M. Lockhart, MD	070
* Curtis C. Marder, MD	134
* Henry G. Mauer, MD	174
* John M. McIlduff, MD	062
Michaeyl J. O'Donnell, MD	218
* James E. O'Dorisio, MD	026
* Khushal D. Patil, MD	102
* John R. Pfeifer, MD	174
* Herbert J. Robb, MD	174
* Gary L. Roth, DO	090
* Wafie D. Roumayah, MD	222
* Saad E. Sabbagh, MD	222
* Frederick W. Sherrin, MD	062
* Mack C. Stirling, MD	070
Ernesto L. Suarez, MD	102
* George T. Sugiyama, MD	106
* Nicholas A. Tepe, MD	174
* Antonio C. Vasquez, MD	022
* W. M. Whitehouse, MD	218
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SPECIALTY – CHN

John P. Manica, MD	174
* Norvil Wyche, MD	222

SPECIALTY – CHP

* William H. Beute, MD	106
* Cynthia Buchalter, MD	070
* Louise Desgranges, MD	062
Ronald J. Dirkse, MD	186
Abraham L. Elson, MD	222
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* Philip C. Haines, MD	106
Mildred L. Herkner, MD	070
* Linda L. Hryhorczuk, MD	222
Faye F. Istanbooly, MD	190
* James W. Johnson, MD	174
Elizabeth D. Kane, MD	134
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Francis C. Pasley, MD	218
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Eva P. Schroeder, MD	222
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Ismail B. Sendi, MD	174
Teymour Sepahbodi, MD	158
* James A. Sonnega, MD	218
Benjamin B. Stamell, MD	222
* Ronald J. Van Valkenburg, MD	034
* D. W. Vander Vliet, MD	106
Martha L. Wells, MD	222
Henry F. Woodworth, MD	222

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William C. Barany, DO	102
Nigel H. Bramwell, MD	102
* Gerald G. Brueckner, MD	126
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Regio T. Penna, MD	030
* Sugendrini P. Ponnampalam, MD	090
Clara Raven, MD	222
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* Laurence R. Simson, MD	090
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* Adnan G. Abbasi, MD	174
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Leandre I. Bautista, MD	034
* William L. Beauregard, MD	174
George T. Bradley, MD	222
Robert J. Brickner, MD	090
* Manuel M. Campos, MD	106
* Chairat Chomchai, MD	222
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* Thomas A. Fox, MD	222
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* Mahesh C. Karamchandani, MD	034
* Steven N. Klein, MD	174
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* James P. Muldoon, MD	106
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* Steven E. Olchowski, MD	222
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Larry R. Pelok, MD	222
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Hans J. Stein, MD	174
* James A. Surrell, MD	106
* Timothy M. Talbott, MD	106
Jacob F. Wenzel, MD	222

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* Martin M. Abbrecht, MD	174
Stanley Alfred, MD	062
Roger K. Allen, MD	090
* Jules Altman, MD	126
Harold E. Anderson, MD	034
* Thomas F. Anderson, MD	218
Saul Appel, MD	098
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* Robert J. Schoenfeld, MD	174
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* Melvin B. Sharf, MD	174
* Lisa A. Shick, MD	174
* Steven M. Shumer, MD	174
Jeffrey M. Shuster, MD	126
* Tor A. Shwayder, MD	222
Marvin D. Siegel, MD	174
Michael T. Siegel, MD	174
Everett B. Simmons, MD	222
* James J. Simons, MD	070
Richard H. Smith, MD	222
* Milton D. Soderberg, MD	134
* Robert M. Soderstrom, MD	062
* Marek A. Stawiski, MD	106
* Julius Stone, MD	126
* Richard A. Stone, MD	126
Marcy L. Street, MD	090
* James D. Stroud, MD	174
F. James Stubbart, MD	162
* Stephen W. Sturman, MD	174
* Kathryn H. Sussman, MD	126
* Antoinette Tanay, MD	174

DR – Diagnostic Radiology

Allen N. Tesser, MD	174
* Martin E. Tessler, MD	174
* Lorna L. Thomas, MD	222
* Patrick J. Tobin, MD	070
Shari F. Topper, MD	174
John L. Ulrich, MD	222
Harold E. Usndek, MD	222
* Kornelius Van Goor, MD	106
* Evelyn E. Vanderveen, MD	106
* Jay Victor, MD	222
* John J. Voorhees, MD	218
* John R. Vydareny, MD	106
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* Thomas P. Waldinger, MD	222
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* Paul W. Wang, MD	102
* K. William Waterson, MD	222
* Kay E. Watnick, MD	222
Wallace C. Weckesser, MD	194
Patrick A. Wegman, MD	206
* Rosalyn Y. Weintraub, MD	174
* William F. Weston, MD	102
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* Edward S. Wikiera, MD	222
* James W. Wilkins, MD	098
Johnson K. Wright, MD	070
Eva L. Youshock, MD	174

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Constantine T. Aries, MD	222
* Dorothy Kahkonen, MD	222
* Michael L. Netzloff, MD	090

SPECIALTY – DMP

* Amir H. Mehregan, MD	158
* David A. Mehregan, MD	158
* Homayoon Rahbari, MD	158
William B. Taylor, MD	218

SPECIALTY – DR

* Gerald R. Aben, MD	090
Dorit D. Adler, MD	218
Ziad Al-Amiri, MD	190
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* Harvey E. Amoe, MD	218
* Michael A. Angileri, MD	222
* Thomas J. Archambeau, MD	090
* George F. Ascherl, MD	022
* Stephen M. Ascherl, MD	022
* Gary T. Augustyn, MD	218
Duke K. Bahn, MD	174
* David E. Baker, MD	218
* George J. Balogh, MD	102
* Michael P. Bartlett, MD	154
* Kenneth P. Bartold, MD	222
Kenneth A. Beil, MD	026
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Donald C. Blake, MD	222
* Edward Bok, MD	106
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* Gary L. Bowman, DO	102
Robert L. Bree, MD	218
John F. K. Brown, MD	174
Richard K. Brown, MD	174
Sandra T. Brown, MD	222
Dennis P. Burke, MD	102
* Julie B. Bush, MD	062
* Costa Buterakos, MD	222
James P. Carl, MD	218
* Jose A. Carrion, MD	194
* Gabriel Ceron, MD	082
David J. Chait, MD	222
Byung H. Chang, MD	062
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Woon-Man Chung, MD	090
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* Elizabeth A. Copland, MD	218
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* Brian M. Craig, MD	222
* Eduardo R. Crotte, MD	102
Gilbert J. Daniel, MD	082
* Robert B. Davis, MD	102
* Alfredo P. De La Fe, MD	090

Alphabetical Listing of MSMS Members by Specialty

** Asterisk beside name denotes AMA membership*

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* John D. Demott, MD 186
* Calixto T. Dimas, MD 095
* Jerry Drake, MD 222
* Michael A. Engel, MD 162
* Jalil B. Farah, MD 174
Gerard P. Farrar, MD 190
Frank M. Fayz, MD 222
* Brian C. Fedeson, MD 106
Robert M. Feldpausch, MD 138
* George L. Figacz, MD 222
Leo S. Figiel, MD 222
* John H. Finger, MD 222
* Robert J. Fles, MD 162
* Kathleen A. Gadwood, MD 102
* Kathleen Gafarian, MD 026
* Mark A. Goddard, MD 222
* Bruce D. Goethe, MD 102
* Kenneth J. Gritter, MD 106
* Eric J. Groskind, MD 222
* Barry H. Gross, MD 222
* Martin L. Gross, MD 222
* Charles A. Guidot, MD 190
* Robert M. Hall, MD 106
Chang-Young Han, MD 222
Andrew J. Hankins, MD 222
* Bijaya A. Hans, MD 126
* Richard R. Harper, MD 186
* Daniel E. Harris, MD 222
* Alan D. Hartz, MD 222
* Kenneth V. Harvey, MD 222
* Richard G. Hayes, MD 222
* James E. Heisel, MD 222
* Jon R. Henke, MD 106
* Jeffrey Herman, MD 154
* Gary M. Herzler, MD 190
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* Richard N. Joyrich, MD 222
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Chandrakant C. Kapdi, MD 222
* James J. Karo, MD 174
Craig B. Karsama, MD 126
J D. Kaurich, MD 162
* Michael M. Kayne, MD 174
* William G. Keating, MD 078
* Hugh H. Kerr, MD 174
* Mahmood A. Khalid, MD 174
* Syed M. Khan, MD 174
* Choong-Man Kim, MD 026
* Chung K. Kim, MD 222
* Dong H. Kim, MD 222
* Joon K. Kim, MD 222
* Kwang-Sung Kim, MD 150
* Seong Jeun Kim, MD 218
* John C. Kirkpatrick, MD 198
* George A. Kling, MD 222
* James E. Knake, MD 218
* James J. Kochkodan, MD 222
* Sudjond Kosim, MD 158
Gary A. Krasicky, MD 222
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* Armand M. LaSorsa, MD 106
* Ethelbert M. Lara, MD 134
* Peter A. Lassing, MD 134
A. Gregory Laurell, MD 102
* Alfredo Lazo, MD 222
* Gary F. Leago, MD 090
Fred Lee, MD 218
* Kok W. Lee, MD 222
* Konstantin R. Loewig, MD 106
Rene D. Loredo, MD 174
* Modesto A. Lorenzo, MD 096
* James W. Lowell, MD 174
* John Lozak, MD 154
Henry J. Lukaszek, MD 214
* Mark L. Lukens, MD 222
* Charles R. Luttenton, MD 106
* Louis S. Magagna, MD 218
* Mark D. Malnor, MD 106
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* Kevin M. Mc Cann, MD 034
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* Michael A. Sandler, MD 222
* Clare A. Scheurer, MD 194
* Meketa M. Schlega, MD 222
Janice M. Schwinke, MD 170
* George C. Scott, MD 222
* Mark C. Segel, MD 222
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Philip M. Setla, MD 222
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Yash K. Shah, MD 222
* Michael J. Shanks, MD 098
Irene C. Sheehan, MD 222
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* Daniel B. Shumaker, MD 222
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* Donald C. Simon, MD 090
* Richard A. Small, MD 222
Patrick A. Sorek, MD 102
Todd C. Space, MD 070
* Ronald A. Sparschu, MD 222
* Mervin J. Specht, MD 054
* Eric Spickler, MD 222

EM – Emergency Medicine

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* Sharon L. Stocking, MD 062
David A. Strahle, MD 062
* Sarada Subramanian, MD 118
Gerard K. Surmann, MD 174
* David F. Tague, MD 102
* Bing T. Tai, MD 090
* Hernani S. Tansuche, MD 194
Soledad C. Te, MD 202
* Kurt E. Tech, MD 222
* William C. Thompson, MD 222
* Barbara A. Threatt, MD 218
Madhusudana R. Tummala, MD 062
Marinus Van Ooyen, MD 114
* Henry L. Vanderkolk, MD 106
Kanak A. Varde, MD 174
* Babu R. Vemuri, MD 222
* Ramanan S. Venkat, MD 222
* Isaias S. Villarosa, MD 222
* Robert A. Vogt, MD 174
* Sanford E. Wagenberg, MD 222
* Joanne B. Walker, MD 218
William L. Walker, MD 014
* Randall R. Walter, MD 222
David C. Wang, MD 222
* Christine Watt, MD 222
* James R. Weeks, MD 014
* Jerrold M. Weiss, MD 090
* Mark W. Weiss, MD 062
Charles J. Weitz, MD 070
Harry L. Weitz, MD 070
Fred K. Wietersen, MD 222
Leslie F. Wilcox, MD 222
* Richard A. Wilcox, MD 222
* Chad R. Williams, MD 106
Charles P. Williams, MD 070
* Peter S. Winston, MD 222
Richard J. Woltersom, MD 070
* David S. Yates, MD 222
* Harvey K. Yee, MD 062
Mark F. Yost, MD 194
Sophie Zaplitny, MD 034
* Pierre A. Zayat, MD 222
* Michael A. Zerbini, MD 174
Alex Zotovas, MD 126
* Steven J. Zweig, MD 014

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James R. Addison, MD 134
Hugh R. Allott, MD 042
* Harry J. Aretakis, MD 126
* Andrew W. Asimos, MD 222
* Douglas L. Bailey, MD 034
Robert A. Barker, MD 070
Susan E. Barlow, MD 022
Keith W. Baron, MD 078
* Kathleen M. Bauer, MD 090
* Gregory W. Baumann, MD 098
Michael W. Beasley, MD 022
Peter Benson, MD 014
* Alan D. Bersted, MD 150
James S. Bicknell, MD 154
Robert A. Bitterman, MD 218
* Joyce M. Blazejewski, MD 174
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Dale C. Blum, MD 070
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* Kenneth M. Brennan, MD 102
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* Thomas C. Burk, MD 022
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* Michael R. Clark, MD 090
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* H. J. De Maagd, MD	106
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James O. Galles, MD	026
Michael R. Gartner, MD	014
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* Richard Gilmartin, MD	114
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* Sherman W. Horn, MD	058
* Ginger Hosko-Williams, MD	058
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* Thomas J. Maier, MD	034
* Stuart A. Malafa, MD	106
* John D. Mc Cabe, MD	218
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* Kevin R. Mc Donald	222
* Myrtle S. Mc Lain, MD	106
* Douglas L. McDonnell, MD	034
Gil H. Mediodia, MD	126
John N. Mehelas, MD	222
Mahendra P. Mehta, MD	062
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* Curt M. Mikulski, MD	070
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Paul R. Pomeroy, MD	222
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* Lawrence R. Schwartz, MD	174
* Douglas J. Segan, MD	090
* Roberto S. Seidner, MD	174
* Sid M. Shah, MD	098
* Gregory D. Shannon, MD	062
* Dolores J. Shelfoon, MD	174
Sherry B. Shepherd, MD	026
* Elmore D. Shoudy, MD	194
* Asfandiar A. Shukri, MD	222
* Neil Siamson, MD	095
Daniel R. Sorenson, MD	154
* Anthony C. Southall, MD	222
* Zbigniew M. Srodulski, MD	102
* Daniel P. Stewart, MD	102
Charles R. Strancke, MD	134
* Gloria M. Strutz, MD	126
William E. Taylor, MD	218
* Michael D. Thompson, MD	218
* Joseph R. Twanmoh, MD	218
D. Mark Upham, MD	014
Leonard W. Van Gelder, MD	186
* Susan N. VandenBerg, MD	106
Eric Vander Haagen, DO	070
Edwin G. Vann, MD	026
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* James M. Volkel, MD	034
John J. Vrbanac, MD	130
* Lisa Wagner-Rogers, MD	102
Gregory L. Walker, MD	090
* Fred L. Wedeking, MD	102
Ross L. Weinstein, MD	174
* Warren K. Westrate, MD	186
Jason M. White, MD	190
* Peter J. Wiebenga, MD	106
* John G. Wiegenstein, MD	090
* Allen J. Williams, MD	158
* Robert M. Williams, MD	150
* Carl D. Winegar, MD	154
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* Barbara N. Wynn, MD	106
* Charles L. Zeller, MD	102

SPECIALTY – END

* Ali A. Abbasi, MD	174
* Lee R. Brunner, MD	170
Jerome W. Conn, MD	218

FP – Family Practice

* Michael S. Garcia, MD	174
* Maria F. Hayes, MD	222
Robert D. Johnson, MD	106
Henry D. Kaine, MD	174
Sander P. Klein, MD	222
* Phillip W. Lambert, MD	190
Lyla J. Leipzig, MD	222
* Donald A. Meier, MD	174
J. Martin Miller, MD	222
* Michael J. Miller, MD	154
* Rebecca M. Norris, MD	102
* John F. Randolph, MD	218
Solomon I. Rosenblatt, MD	174
* Vinod B. Sanghi, MD	222
* Charles I. Taylor, MD	174
David L. Thomson, MD	126
Nestor B. Tomycz, MD	062
* Mohammad S. Zafar, MD	222

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* Tama D. Abel, MD	218
Brian A. Adamczyk, MD	098
Albert C. Adams, MD	062
* Robert P. Adams, MD	118
Vincent B. Adams, MD	222
* Kirk J. Agerson, MD	106
Alka Aggarwal, MD	222
Antonio A. Aguirre, MD	222
Donald J. Aiken, MD	090
* Steven A. Aiken, MD	222
Nancy A. Ajemian, MD	222
* Joe Alberding, MD	102
* Scott T. Aldridge, MD	042
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Donna L. Angell, MD 222
Roger D. Annis, MD 090
* Peter B. App, MD 106
* Robert G. App, MD 190
* Lloyd E. Appell, MD 102
James A. Applegate, MD 106
* Roger W. Archer, DO 222
Janet S. Arnold, MD 126
William J. Arnold, MD 222
Leslie H. Arwin, MD 218
James C. Askins, MD 098
Russell M. Atchison, MD 218
Avery J. Aten, MD 014
David E. Atkinson, MD 054
Herbert A. Atkinson, MD 026
James E. Atkinson, MD 018
* Domenico S. Ausiello, MD 094
Walter C. Averill, MD 190
* Catherine M. Baase, MD 154
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Ronald P. Baker, MD 026
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Boris M. Beckert, MD 134
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* W. Bruce Bennett, MD 094
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Fredk. E. Bentley, MD 218
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* Mary Ellen Benzik, MD 034
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* Kenneth S. Berneis, MD 010
David J. Beyer, MD 126
* Atmaram B. Bhansali, MD 034
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* Lucy R. Canaday, MD 218
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* Silas C. Cheuk, MD 222
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Richard M. Czop, MD 090
* Doris E. Dahlstrom, MD 102
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Robert D. Danforth, MD 222
* Henry G. Danielsky, MD 094
Hamazasp B. Darian, MD 126
Robert J. Darios, MD 090
* Bruce N. Davenport, MD 090
Clyde P. Davenport, MD 190
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* William J. De Mots, MD 114
* Paul T. De Witt, MD 018
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* Dennis F. Dettloff, MD 014
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* Rebilo A. Diccion, MD 114
* Timothy K. Dickinson, MD 010
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* Thomas M. Dobbins, MD 034
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Ronald A. Farber, MD	214
* Angel Farina, MD	222
Alan R. Fark, MD	106
* Sara Fassihi, MD	222
Grover R. Fattic, MD	026
John G. Faughnan, MD	050
William G. Fenner, MD	222
* Jerry Ferrell, MD	154
* Kevin M. Fickenscher, MD	102
Lynn E. Field, MD	014
Marvin D. Fields, MD	098
* Donald D. Finlayson, MD	042
William A. Fishbeck, MD	154
Cynthia L. Fisher, MD	174
* Robert J. Fisher, MD	218
Donald N. Fitch, MD	050
Erwin L. Fitzgerald, MD	106
* Linval K. Fleetwood, MD	062
* James C. Flick, MD	162
James E. Flood, MD	106
* Thelma I. Flores, MD	222
* Lawrence G. Foe, MD	106
* James D. Forshee, MD	062
* Douglas B. Forsyth, MD	190
* Henry T. Forsyth, MD	206
James A. Fortune, MD	126
Gregory J. Forzley, MD	106
Winslow G. Fox, MD	218
* Laura A. Fox-Smith, MD	126
Paul L. Fraiberg, MD	222
James M. Franck, MD	066
Robert S. Fredrick, MD	162
Mark A. Fredrickson, MD	106
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James R. Freeman, DO	014
Lee S. Fruman, MD	174
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Douglas A. Furman, MD	170
David Z. Gadzinski, MD	138
* Michael L. Gambel, MD	222
Thomas Ganos, MD	222
Herand Garapetyan, MD	046
* Robert E. Gardner, MD	066
Warren R. Garr, MD	118
* Delmer E. Garrison, MD	218
Robert E. Garrison, MD	162
* Donald B. Garvin, MD	022
Alex Gaynor, MD	222
* Gary R. Gazella, MD	222
John R. Gehman, MD	096
Norman F. Gehringer, MD	174
Edgar J. Geist, MD	174
* Donald G. Gerard, MD	106
* Roy J. Gerard, MD	090
Robert R. Gibson, MD	154
William P. Gifford, MD	090
Norma Gilbert, MD	178
* Gary D. Gillespie, MD	090
Rodney P. Gilreath, MD	222
* David A. Ginnebaugh, MD	126
* William R. Gladstone, MD	054
Daniel Goldberger, MD	102
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Yon Graham, MD	102
* William G. Grannis, MD	126
* Erwin L. Grasman, MD	162
Scott A. Graves, MD	062
Thomas G. Graves, MD	126
Lynn S. Gray, MD	026
Morris Z. Greenberg, MD	222
Emerich Grinbaum, MD	062
* Frederick J. Grose, MD	174
* James M. Grost, MD	090
Paul G. Gruca, MD	074
Ellen K. Gryniewicz, MD	218
* Edwin H. Gullekson, MD	062
Charles R. Gumpper, MD	062
Arun Gupta, MD	158
* Feridun M. Gurol, MD	174
* Eric K. Gustafson, MD	106
Julius J. Gutow, MD	062
Michael Haas, MD	222
Manuel B. Hababag, MD	126
Hilda A. Habenicht, MD	098
* Douglass A. Haddock, MD	102
* Robert K. Hafford, MD	022
* Fremont D. Halboth, MD	062
William A. Haley, MD	222
* James K. Hall, MD	074
Patricia S. Hallman, MD	106
Loren B. Hamel, MD	026
Lowell G. Hamel, MD	026
* Mark S. Hamilton, MD	194
Dale A. Hanson, MD	062
Daniel D. Hardie, MD	134
Daniel R. Harro, MD	106
Gordon R. Harrod, MD	090
* Robert T. Hartman, MD	218
Walter W. Hassig, MD	222
William T. Hassig, MD	222
* Carl W. Hawkins, MD	042
* Lawrence S. Hawkins, MD	018
Leatha B. Hayes, DO	190
* Paul N. Hayes, MD	054
* Thomas L. Haynes, MD	106
* Gregory L. Hazle, MD	106
George L. Heenan, MD	026
* Dale W. Heeres, MD	162
Daniel D. Heffernan, MD	218
Charles H. Heffron, MD	114
Paul D. Heilborn, MD	098
* Susan P. Heinrich, MD	214
* Kurt P. Helgerson, MD	102
Ralph F. Helzerman, MD	114
Vincent C. Henderson, MD	026
* Mark R. Henry, MD	034
* Mary Herlihy, MD	190
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* Gregory H. Hessler, MD	026
* Charles J. Heyka, MD	170
John M. Hickner, MD	050
Leland A. Hickox, MD	142
* John F. Hildebrandt, MD	094
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* Cecelia F. Hissong, MD	222
* Sean J. Hoban, MD	190
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* George J. Hoekstra, MD	102
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* Kevin M. Holleman, MD	102
* David S. Hollett, MD	174
Werner Hollstein, MD	090
* C. Jeffrey Holmes, MD	074
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* Andrew J. Hopkins, MD	222
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* Andrij W. Horodysky, MD	126
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* J Christopher Hough, MD	154
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* Robert E. James, MD	062
* Joel J. Jarvis, MD	162
* Eronico P. Javellana, MD	086
* Peter J. Jennings	090
Larry E. Jennings, MD	098
* Ronald L. Jenson, MD	190
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* Edward N. Johnson, MD	042
Jo Ann Johnson, DO	062
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* Bela T. Lanczy, DO	082
* Robert E. Landick, MD	090
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* Paul E. Larkey, MD	090
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* John A. Mulder, MD	162
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"I'm practicing medicine the way I think it should be practiced, sans the paperwork and administrative overload."

Owen Brodie, MD, joined CompHealth's locum tenens medical staff in 1989, after 21 years in private practice. Since then he's worked in temporary assignments in state facilities, filled in for attending physicians, covered for private practitioners across the country.

A pilot. A historian. A board-certified psychiatrist. Southern to a fault. Owen Brodie knows...

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* David B. Munro, MD	098
* Mary E. Murphy, MD	126
Bridget Murray, MD	082
Terri Myers, MD	062
* Alberto Nacif, MD	118
* Farzin Reza Namei, MD	190
* Marcia S. Nansel, DO	010
Sharon W. Nash, MD	094
Sulayman H. Nassar, MD	062
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* Richard Y. Ng, MD	174
* Quan D. Nguyen, MD	090
* Luis A. Nino, MD	222
Donald A. Nitz, MD	062
* Linda D. Norrell, MD	062
Joseph I. Nosanchuk, MD	174
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David L. Olson, MD	150
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Jon D. Paget, MD	090
* Jaak M. Pahn, MD	042
* Thomas R. Palmer, MD	222
Dennis J. Pank, MD	062
* Dana D. Panknin, MD	014
* Kenneth A. Parada, MD	170
Mary Ellen Pardi, MD	102
Kris Parnicky, MD	222
Eleanor M. Parshall, MD	114
Cheryl L. Parsons, MD	014
B. G. Patel, MD	174
* Suman Patel, MD	222
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* Roger D. Paterson, MD	130
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* Richard P. Payea, MD	095
* Edward Pazuchowski, MD	126
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James F. Peggs, MD	218
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Woodrow H. Pickering, MD	062
Charles B. Pierson, MD	026
* Boleslaw Pietruszka, MD	062
* Kevin L. Piggott, MD	134
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* Jack T. Pinney, MD	154
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* Christopher J. Pogliano, MD	066
* Emery C. Polasek, MD	102
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John M. Proos, MD	026
Russel F. Proud, MD	222
Donald Prouty, MD	074
* Poala D. Prude-Bogar, MD	062
* Philip C. Ptacin, MD	034
William P. Purfield, MD	114
* Scott R. Pynnonen, MD	082
* Fe F. Quines, MD	210
Ernest V. Quiroz, MD	106

HEPATITIS B VACCINE DISCOUNT AVAILABLE TO MSMS MEMBERS

Bond Wholesale Pharmaceutical and Medical Supply is offering Enerix-B brand of hepatitis B vaccine to MSMS members at $39.99 per single shot vial.

New OSHA standards require Michigan physicians to provide free hepatitis B vaccines to all employees exposed to bloodborne diseases.

For detailed information call Sandy at

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Alphabetical Listing of MSMS Members by Specialty

** Asterisk beside name denotes AMA membership*

FP – Family Practice

Susan L. Radecky, MD 106
* Russell M. Ragan, MD 096
* Frank P. Raiford, MD 222
* Gerald Rakotz, MD 126
* Joseph J. Rambo, MD 026
* Benjamin R. Ramos, MD 222
* Dennis M. Ramus, MD 126
* Richard M. Rankl, MD 062
* Christopher J. Rasak, MD 222
Richard S. Rasmussen, MD 106
* James R. Rawlinson, MD 090
William R. Rech, MD 174
Chada N. Reddy, MD 222
Stephen D. Redman, MD 154
* David G. Reed, MD 126
* Jesse H. Reed, MD 158
* Donald B. Reinders, MD 166
* P. Graydon Reinoehl, MD 214
Richard J. Remsberg, DO 074
Fredric A. Reyelts, MD 106
Manual Reyes, MD 026
Robert C. Richard, MD 106
James P. Richards, MD 014
Mark M. Richardson, MD 090
Michael T. Richardson, MD 134
William N. Richardson, MD 174
* Liana G. Rinzler, MD 106
Raymond J. Rion, MD 014
* Cathryn I. Roberts, MD 190
Shirley Robertson, MD 090
Orlo J. Robinson, MD 222
* Stanley R. Robinson, MD 090
Stephen W. Robinson, MD 102
* David J. Rodgers, MD 174
* Peter J. Rodin, DO 222
Thomas F. Roe, MD 174
William B. Rogers, MD 198
Abraham S. Rogoff, MD 222
George P. Roller, MD 190
* Gary T. Roome, MD 062
A. Leslie Rose, MD 050
* Edward A. Rose, MD 174
Bernard A. Rosen, MD 154
Louis Rosenbaum, MD 134
Frederick C. Rosin, MD 190
Tina M. Rossi, MD 014
Katherine A. Roth, MD 090
* Robert L. Roty, MD 206
* Russell C. Rowan, MD 034
Steven J. Rowe, MD 082
Kristine O. Rudolf, MD 174
Rainer A. Rudolf, MD 174
* Gary E. Ruoff, MD 102
Emil F. Rupprecht, MD 222
Richard D. Rusak, MD 150
* Jack Ryan, MD 222
* Tom T. Saad, MD 010
Bernard A. Sage, MD 222
* F. Michael Saigh, MD 054
* Louis E. Sanford, MD 094
* Scott A. Sanford, MD 162
Narciso D. Santiago, MD 190
* Peter T. Savage, MD 010
* Duane M. Saxton, MD 186
G. L. Schaiberger, MD 095
John F. Scheerer, MD 218
Serge P. Schillio, MD 026
David Schindler, MD 174
Henry Schlesinger, MD 222
* David J. Schluze, MD 222
* Robert W. Schmidlin, MD 062
* Elaine M. Schmidt, MD 162
Norman L. Schmitt, MD 222
Harry E. Schneiter, MD 106
* Jerome J. Schneyer, MD 174
Charles A. Schoff, MD 154
* David J. Schriemer, MD 102
Clarence H. Schultz, MD 222
Donald V. Schultz, MD 222
Michael L. Schultz, MD 190
* Frederick C. Schwartz, MD 170
* Howard B. Schwartz, MD 222
Joseph A. Schwartzberg, MD 222
Thomas L. Schwenk, MD 218
* Caroline G. Scott, MD 190
Neil R. See, MD 026
Steven K. Selin, MD 106
* Larry J. Sell, MD 222
Robert Selman, MD 174
* James W. Setchfield, MD 106
Kantilal M. Shah, MD 222
Rajesh P. Shah, MD 098
Rashmikant M. Shah, MD 110
Devendra K. Sharma, MD 095
* David L. Sharp, MD 106
* Marguerite R. Shearer, MD 218
* Mark R. Shebuski, MD 082
* Kamran F. Sheikh, MD 222
* Donald A. Sheill, MD 162
V. Lowell Sheline, MD 074
Sharon L. Shelton-Fawaz, DO 094
Luke H. Sheng, MD 118
* Douglas D. Sherk, MD 134
* Eber B. Sherman, MD 058
* John W. Sherman, MD 190
* James F. Shetlar, MD 190
* William M. Short, MD 134
Patricia Z. Showerman, DO 118
* Sherman C. Shultz, MD 114
I. Walter Silver, MD 222
Milton F. Simmons, MD 126
Ronald D. Simmons, MD 226
* Lewis E. Simoni, MD 062
Edward J. Skully, MD 222
Michael J. Slavin, MD 190
Henry Small, MD 222
* Ronald H. Smalley, MD 062
* Deborah Y. Smart, MD 222
David B. Smith, MD 050
David J. Smith, MD 090
* Duane E. Smith, MD 202
* Gary S. Smith, MD 154
George F. Smith, MD 090
* Mervyn W. Smith, MD 106
Mindy A. Smith, MD 218
Neal A. Smith, MD 074
Robert D. Smith, MD 198
Thomas G. Smith, MD 226
Timothy V. Smith, MD 186
William L. Smith, MD 070
Michael E. Smothers, MD 222
Frank J. Soler, MD 222
Alex E. Solik, MD 062
* Abraham B. Solomon, MD 222
* Susan J. Solomon, MD 095
Craig R. Sonke, MD 154
* Ashok R. Sonnad, MD 074
Norman C. Sooy, MD 170
* Carol S. Southland, MD 162
James E. Spens, MD 014
* James R. Spindler, MD 018
* Dawn E. Springer, MD 090
Jack M. Stack, MD 074
* John M. Stafford, MD 026
Meyer Stamell, MD 222
James D. Stamp, MD 222
* Linda K. Stanley, MD 026
* William J. Starbird, MD 110
* Gary W. Stencel, MD 126
* William K. Stetson, MD 062
Charles E. Stevens, MD 094
Mark C. Stevens, MD 134
Tommy S. Stevens, MD 062
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* F. James Stewart, MD 170
* Judith E. Steyer, MD 134
Douglas F. Strong, MD 206
* James P. Strong, MD 182
L. Lamar Styer, MD 186
Adolph W. Suksta, MD 126
Timur Sumer, MD 062
* Barbara Ann Supanich, MD 150
Marion D. Sutton, MD 154
Michael L. Szymanski, MD 218
Gerald M. Takala, MD 182
Janet L. Talmo, MD 106
* Irmina Targowski, MD 102
Glenn E. Taylor, MD 174
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* Walter C. Taylor, MD 222
* Thomas M. Teal, MD 206
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Stephen G. Tepastte, MD 090
* Barbara C. Tess, MD 126
Steven J. Thiry, MD 218
* Jean B. Thomas, MD 106
* Thomas K. Thomas, MD 222
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Margaret E. Thompson, MD 106
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* Mary E. Thorne, MD 090
* Richard Thurmer, DO 102
* Barbara Tilben, DO 206
* Rodrigo Tobar, DO 174
* Rodrigo R. Tobar, MD 222
Timothy J. Tobolic, MD 106
* Richard M. Tooker, MD 102
* David W. Torkelson, MD 190
Lori-Ann P. Torreano, MD 134
Estelle P. Torres, MD 186
Robert J. Toteff, MD 222
* Gaylord A. Treadway, MD 022
* Daniel Triezenberg, MD 142
* Wayne M. Trinklein, MD 090
* Mark G. Trudell, MD 062
Bruce J. Trusock, MD 082
* Craig B. Tubbs, MD 074
Douglas B. Tubman, MD 022
Seth D. Udlis, MD 026
* Benjamin T. Ulep, MD 134
* Lawrence A. Ulmer, DO 102
Robert J. Urban, MD 204
* Otonas Vaitas, MD 174
Dennis E. Van Alst, MD 226
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* Gerald G. Van Arendonk, MD 102
Joseph P. Van Ark, MD 090
Bruce L. Van Cleave, MD 174
John C. Van Dalson, MD 070
* Hendrik C. Van Den Ende, MD 134
* Frederick W. Van Duyne, MD 062
Philip L. Van Lente, MD 106
Glenn R. Van Noord, MD 106
Keith Van Oosterhout, MD 026
Fredk I. Van Wagnen, MD 098
* David A. Van Winkle, MD 162
Tunis Vanden Berg, MD 106
* Scott D. Vander Hill, MD 142
John Vander Molen, MD 106
William L. Vander Vliet, MD 186
* Gerald A. Vander Voord, MD 090
Howard L. Varney, MD 096
Charles T. Vear, MD 078
Sasikala Vemulapalli, MD 062
Steven J. Verkaik, MD 186
* A. N. Vettraino, MD 174
Douglas L. Villa, MD 054
* Robert L. Vitu, MD 190
Jan J. Vlach, MD 070
James L. Voigt, MD 102
John A. Vollmer, MD 126
Kandarp K. Vora, MD 150
* Carol J. Voytas, MD 102
* Christian E. Wagner, MD 106
Everal M. Wakeman, MD 222
* Jerry L. Waldyke, MD 218
* John A. Walen, MD 106
* Paul A. Walk, MD 034
* John F. Walstrum, MD 010
* Daniel L. Walter, MD 062
* Jerome H. Wassink, MD 186
Mary L. Watts, MD 126
* Alan P. Weamer, MD 062
Lester E. Webb, MD 190
* William R. Webb, MD 222
* Laurence G. Weber, MD 102
* Robert M. Weber, MD 062
* Edward R. Weddon, MD 098
Thomas A. Weeber, MD 106
Suzanne Wehrenberg, MD 170
* Lori Weide, MD 126
Alan H. Weitenberner, MD 126
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Timothy T. Wellemeyer, MD 090
Paul T. Werner, MD 174
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* Richard L. Westerman, MD 102
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Robert G. Wetterstrom, MD 218
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* Frank T. White, MD 062
* Louis I. White, MD 174
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Mary C. Whitmer, DO 050
John L. Wiant, MD 174

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* David A. Wild, MD	130
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* John H. Williams, MD	222
Joshua S. Williams, MD	222
Richard F. Willis, MD	014
* Clinton W. Wilson, MD	026
Elizabeth K. Wilson, DO	050
Christina L. Winder, MD	126
* Jill S. Winkler	090
Bruce K. Winner, MD	106
* Sheryl A. Wissman, MD	222
David Witte, MD	214
Leland W. Wolf, MD	078
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Alfred L. Wood, MD	222
* William H. Woodhams, MD	102
* Bernard J. Woodley, MD	222
* David M. Woodliff, MD	018
Edwin S. Woodworth, MD	118
* Thomas B. Woodworth, MD	154
* Michael J. Worzniak, MD	114
* Gary A. Wozniak, MD	222
* C. David Wright, MD	095
* Terrence P. Wright, MD	106
Barbara L. Wuehrmann, MD	106
* John O. Wycoff, DO	090
S. A. Yannitelli, MD	034
* G. James Yobst, MD	154
* Kenneth E. Yokosawa, MD	062
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* John R. Young, MD	034
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* Barina Y. Zado, MD	062
Anton Zadurowycz, MD	222
* Mark A. Zainea, MD	222
* Louis R. Zako, MD	222
* Ronald C. Zapf, MD	214
* Daniel M. Zelko, MD	062
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* Robert H. Burke, MD	218
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* Larry A. Adler, MD	218
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Thomas J. Alexander, MD	174
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* James A. Fuson, MD	106
Balvant K. Ganatra, MD	062
Eugene A. Gelzayd, MD	174
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* Thomas P. Gushurst, MD	102
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Glenn I. Hiller, MD	222
* Richard W. Houston, MD	102
* Randall S. Jacobs, MD	174
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* Ramon R. Joseph, MD	222
* Amita Kakarla-Maganti, MD	190
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* Varin U. Kule, MD	022
* Jeffrey A. Leinicke, MD	162
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Richard S. Mc Caughey, MD	174
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* JoAnn E. Ormand, MD	106
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SPECIALTY – GER

Iris F. Boettcher, MD	106
Elizabeth C. Imeson, MD	090
John C. Kretzschmar, MD	222
Sheffick J. Moroun, MD	222
Steven M. Stein, MD	222
Harold A. Timreck, MD	150
Bernard Weston, MD	222

SPECIALTY – GO

* Vinay K. Malviya, MD	222

SPECIALTY – GP

Rukmani Achari, MD	222
James R. Adams, MD	222
Isa S. Ajlouni, MD	222
Imad Al-Azem, MD	222
Leonard C. Aldrich, MD	082
Barry H. Alford, MD	218
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* Reynaldo B. Arceno, MD	222
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* Muzaffar K. Awan, MD	222
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* Loren M. Baylis, MD	174
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* Victor A. Berglund, MD	102
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Eduardo T. Bermudez, MD	190
William E. Berndt, DO	074
Joseph E. Berry, MD	222
George D. Beyer, MD	062
B. Wayne Bingham, MD	090
Gertrude K. Black, MD	090
Larry L. Blair, MD	018
Lowell E. Blanchard, MD	114
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Gary M. Bomphray, MD	022
* William H. Bond, MD	162
* Warren E. Bontrager, MD	150
Edmund T. Bott, MD	222
Horace F. Bradfield, MD	222
Wilbur G. Braham, MD	198
Zane A. Brashares, MD	098
Harvey H. Brinkman, MD	095
Charles H. Brown, MD	222
Harold E. Brown, MD	026
Thomas A. Brown, MD	222
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GP – General Practice

* Jack H. Buck, MD	094
Lester A. Buhler, MD	194
Jerry E. Bulthuis, MD	186
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Chauncey G. Burke, MD	174
* Quinter M. Burnett, MD	042
F. M. Burroughs, MD	106
* John J. Burroughs, MD	158
Harry S. Burstein, MD	222
Joseph F. Burtka, MD	174
Harry R. Butler, MD	222
* Jaime T. Calaguas, MD	222
Alice F. Campbell, MD	034
Cesar P. Casten, MD	095
Edgar H. Caughey, MD	222
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Donald Chandler, MD	106
* Emily M. Chang, MD	126
Elwood M. Chipman, MD	206
Arthur M. Clark, MD	222
William P. Clark, MD	222
John M. Clarkson, MD	046
Susan T. Clarkson, MD	046
George R. Clinton, MD	090
Edgar G. Cochrane, MD	222
Versa V. Cole, MD	170
Charles E. Conaway, MD	110
Aeneas Constantine, MD	014
Carlton L. Cook, MD	114
* Maria Corondan, MD	126
Stanley A. Cosens, MD	022
* Frank I. Costa, MD	158
* Michael J. Crawford, MD	106
Kenneth R. Crawley, MD	102
Austin G. Craymer, MD	138
Maria V. Cserhalmi, MD	222
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* Leticia T. Dantes, MD	190
Donald L. Davidson, MD	066
Kristy Davis, DO	198
Roy A. Davis, MD	106
* Richard C. Dayton, MD	174
* Antonio R. De Leon, MD	222
* Dario C. De Paulis, MD	126
George C. De Smyter, MD	222
John S. De Tar, MD	218
H. Louis De Vito, MD	174
Jess J. De Young, MD	166
Betty J. DeLawrence, MD	222
* Joel T. Dean, MD	194
* Jeffrey S. Deitch, DO	126
Michael L. Demars, MD	174
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Willard D. Den Houter, MD	218
* Carlton K. Dettman, MD	062
Leon A. Dickson, MD	222
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* Donald A. Dunlop, MD	096
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George A. Ellis, MD	190
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Alan J. Elnick, MD	022
William K. Emery, MD	026
Joseph M. Evans, MD	222
Matthies Evans, MD	090
Atanasio C. Fajardo, MD	222
* Luis Fanego, MD	222
Edwin H. Fenton, MD	194
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Virginia M. Ferrara, MD	222
* Dozier N. Fields, MD	154
Duward L. Finch, MD	034
* Daniel L. Fink, MD	222
Elizabeth Fischer, MD	170
* Zdzislaw Fiutowski, MD	222
Thomas W. Fochtman, MD	106
Leonard M. Folkers, MD	090
William M. Follis, MD	022
Silvio P. Fortino, MD	090
Wallace M. Foster, MD	222
John R. Franck, MD	066
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John W. Freud, MD 158
Morris E. Friedman, MD 026
Melvin J. Frieswyk, MD 186
* Faith B. Fritsch, DO 090
Lyle W. Frost, MD 218
Andrew A. Fulgenzi, MD 126
Fred C. Garlock, MD 058
* Paul F. Gerigk, MD 218
* Elisa C. Geronaga, MD 122
Steven N. Gervae, MD 182
* Richard E. Gibson, MD 102
Robert E. L. Gibson, MD 122
Elmer A. Goerke, MD 222
* Alfonso Gonzalez, MD 186
C. Robert Good, MD 106
Samuel B. Goss, MD 222
Salah E. A. Gouda, MD 222
Michael P. Grant, MD 190
Cornell Greavu, MD 110
John B. Greene, MD 222
* James M. Greenwood, MD 070
S. Phillip Grillo, MD 218
Neil E. Grossnickle, MD 204
Hugh L. Grover, DO 062
Elizabeth A. Gurden, MD 206
* Henry V. Guzzo, MD 038
Thomas L. Hackett, MD 098
Richard D. Hackley, MD 062
Leslie P. Haefele, MD 222
F. Howard Hague, MD 042
Ellen R. Haines, MD 222
Leonard Haking, MD 222
Lee H. Halsted, MD 174
Herbert E. Hamel, MD 042
Kuno Hammerberg, MD 096
* Merle B. Haney, MD 110
* John B. Hannah, MD 206
Lawrence A. Hansen, MD 222
Frank G. Harrell, MD 102
Louis E. Harrington, MD 090
* W. Richard Harris, MD 162
William H. Harrison, MD 090
Robert J. Hartquist, MD 222
* Ahmed A. Hassan, MD 194
Orville J. Hastings, MD 222
* Richard L. Hatton, MD 090
Paul A. Haupt, DO 146
* James D. Hays, MD 186
Paul A. Heidel, MD 070
Herbert O. Helmkamp, MD 190
* Alan K. Hendra, MD 126
Edmond R. Henelt, MD 078
Anita M. Herald, MD 162
Jason Hodges, MD 222
* Ralph M. Hodges, MD 102
Russell J. Holcomb, MD 194
Frederick R. Holland, MD 154
George F. Holmes, MD 222
* Eugene A. Homeister, MD 222
George C. Hopkins, MD 222
Mark D. Horness, MD 154
Glenn W. House, MD 094
Larry L. Houts, DO 198
Willard H. Howard, MD 102
* Herbert E. Humphrey, MD 034
Richard A. Huntley, MD 178
Aliqemal Hysni, MD 222
Peter H. Iacobell, MD 222
* Elsa A. Isip, MD 222
John M. Jacobowitz, MD 102
* Wadi J. Jibrail, MD 026
Helene M. Johnson, MD 026
J. Frederic Johnson, MD 174
M. Culver Jones, MD 022
* Franz W. Jordan, MD 190
* Daniel D. Joseph, MD 130
Walter A. Kaplita, MD 222
Saul Karch, MD 222
* Paul H. Karr, MD 062
Arnold Kass, MD 222
* William H. Kaufman, MD 222
William R. Kavanaugh, MD 102
Edward N. Keegstra, MD 026
John J. Kelly, MD 222
Donald M. Kennett, MD 062
Howard J. Kerr, MD 162
* Elie G. Khoury, MD 174
* George E. Kieler, MD 150
* Kwan Soo Kim, MD 034
Seong C. Kim, MD 198
William W. Kitti, MD 070
* Gary H. Knapp, MD 222
Lubomira S. Kocur, MD 110
Edward J. Koerber, MD 222
Robert C. Kolesar, MD 154
Miroslav Kollar, MD 126
* Joseph Kopchick, MD 094
Martin J. Kozachik, MD 090
Anthony E. Kozlinski, MD 222
Henry J. Kreulen, MD 106
Francis X. Krynicki, MD 222
Francis S. Kucmierz, MD 222
Albert A. Kuhn, MD 222
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* George H. Mayol, MD 014
Stewart C. Mc Arthur, MD 096
John W. Mc Crea, MD 202
* L. Robert Mc Elmurry, MD 090
Leland R. Mc Elmurry, MD 090
* Marvin E. Mc Elroy, MD 150
Francis J. Mc Evoy, MD 174
Roscoe I. Mc Fadden, MD 214
Edna C. Mc Inerney, MD 050
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* Crispo G. Rejano, MD 222
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* Edward H. Rodda, MD 022
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Robert Sinanian, MD 102
Nelson Singer, MD 126
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* James Sirajuddin, MD 214
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Glenn L. Smith, MD 110
Maurice J. Smith, MD 062
* Michael W. Smith, MD 218
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* Adelbert L. Stagg, MD	214
Aaron C. Stander, MD	190
Saul C. Stein, MD	222
Charles G. Steinke, MD	054
* Wesley F. Stephenson, MD	046
Leonard H. Stern, MD	222
* William K. Stewart, MD	030
Dwight E. Stith, MD	222
* Robert G. Streicher, MD	158
Samuel Sugar, MD	098
* William F. Sutter, MD	138
* Raymond L. Sutton, MD	095
Raymond H. Suwinski, MD	222
Lionel F. Swan, MD	222
Jaime F. Tan, MD	086
Steven G. Tarangle, MD	034
William H. Taurence, MD	222
* Amos Taylor, MD	222
Douglas H. Taylor, MD	026
Myron A. Tazelaar, MD	034
Henry A. Tazzioli, MD	222
Ralph Ten Have, MD	106
Hugh O. Thompson, MD	222
Sadie Thumim, MD	222
Donald G. Trapp, MD	078
Steven D. Trombly, MD	126
Jack L. Tromp, MD	018
William C. Trowbridge, MD	106
* George A. Tumaneng, MD	062
Chester J. Ujda, MD	222
* William G. Underhill, MD	190
* William R. Urbancic, MD	126
Vicente Uy, MD	110
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Peter J. Verkaik, MD	186
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* Barry F. Waite, MD	190
James D. Walker, MD	062
John F. Walters, MD	034
Nathaniel J. Walton, MD	030
* Aaron K. Warren, MD	038
Desmond P. Waters, MD	138
Thomas M. Watkins, MD	014
John C. Watts, MD	222
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Casimir P. Weiss, MD	222
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* Howard S. Wharton, MD	034
R H. White, MD	174
Keith H. Whitehouse, MD	114
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Arthur A. Wittenberg, MD	222
* Robert M. Wittig, MD	222
Bonnie R. Wolfram, MD	170
Ralph F. Woodbury, MD	222
George H. Wynn, MD	114
Morton I. Yarrows, MD	222
Michael J. Zitter, MD	226
Margaret H. Zolen, MD	102

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Sigmund A. Zukowski, MD	222

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Joseph A. Arends, MD	174
* William S. Barry, MD	034
Carolyn W. Bird, MD	174
* Ronald M. Davis, MD	090
* Jennifer A. Doyle, MD	218
William N. Hall, MD	090
Willard R. Lenz, MD	222
* Virginia Y. Mesa, MD	062
Richard B. Michelson, MD	174
Fred T. Nobrega, MD	174
* Ronald D. Peterson, MD	222
John R. Petrasky, MD	050
Eric H. Phillips, MD	102
James C. Terrian, MD	042
Charles M. Wylie, MD	218
Begum Zubeida, MD	222

SPECIALTY – GS

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Ram N. Agrawal, MD	098
Syed S. Akhtar, MD	190
* Robert P. Albers, MD	186
Roxie M. Albrecht, MD	106
Lucilo C. Alcantara, MD	222
Cornelius A. Alexander, MD	102
Abd A. Alghanem, MD	062
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Luis G. Barbe, MD 222
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Eduardo V. Barlan, MD 130
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* Joseph S. Bassett, MD 222
* Firooz Bassir, MD 222
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* Sussan M. Bays, MD 190
Jeriel A. Beard, MD 142
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Pamela Benitez, MD 222
Carl G. Benner, MD 070
Clifford D. Benson, MD 222
John W. Berghuis, MD 186
* Roy T. Bergman, MD 090
* Ramon Berguer-Sandez, MD 222
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Robert C. Birks, MD 222
Vernon B. Blaha, MD 150
Alexander Blain, MD 222
* Marcus G. Blass, MD 010
* David H. Blinkhorn, MD 222
Geoffrey B. Blossom, MD 174
* John E. Boccaccio, MD 222
* William C. Bock, MD 026
* Jason H. Bodzin, MD 222
* Gregory A. Bohn, MD 162
* Norman J. Bolton, MD 222
* Steven Bolton, MD 174
* Virgilio Bonet, MD 062
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* Robert G. Borchak, MD 222
* E. Borhani-Azar, MD 158
* Philip G. Borozan, MD 102
* Daniel K. Borreson, MD 106
Jan K. Bosch, MD 106
Rajendra Bothra, MD 222
* Dennis A. Boysen, MD 190
Harvey J. Bratt, MD 106
Frank N. Bredau, MD 222
Morris S. Brent, MD 222
John E. Brisson, MD 222

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* Arnold L. Brown, MD 174
Arthur L. Brown, MD 102
* Frederick B. Brown, MD 162
Robert S. Brown, MD 154
* Daniel P. Browning, MD 174
Kneale M. Brownson, MD 070
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Kenley F. Burkhart, MD 010
Richard E. Burney, MD 218
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J. Max Busard, MD 162
Robert C. Buslepp, MD 098
Abelardo V. Bustillo, MD 118
* Michael J. Busuito, MD 222
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C. Glen Callander, MD 102
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Richard E. Campbell, MD 094
* Ruth B. Campbell, MD 222
* A. M. Capili, MD 218
Eugene T. Capuzzi, MD 222
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* Jian Chen, MD	222
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* Kong C. Choi, MD	062
Sang H. Choi, MD	174
* Jim Y. Chow, MD	086
* Joel W. Clay, MD	126
* Robert K. Cleary, MD	218
Robert H. Cleland, MD	050
Frederick L. Clement, MD	102
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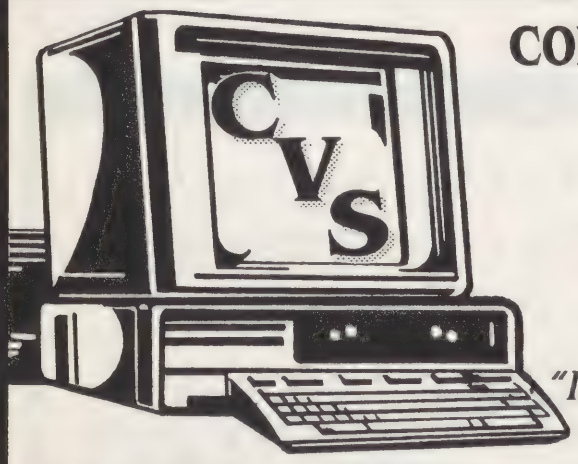
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* Harriette M. Horst, MD	222
* Verne L. Hoshal, MD	218
Gope C. Hotchandani, MD	054
Frank W. Howard, MD	026
Roger S. Howard, MD	174
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* Hubert C. Huebl, MD	222
* Shivappa V. Hulbanni, MD	222
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F. Allen Hutchinson, MD	106
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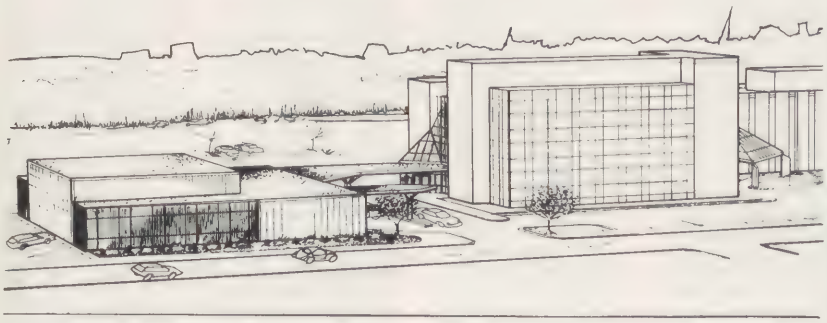
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■ ■ ■

For confidential consideration, send cover letter and CV to
Stan Gruhn, M.D., Riverview Clinic
P.O. Box 551, Janesville, WI 53547-0551

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Miguel F. Perez, MD 062
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Efren F. Platon, MD 174
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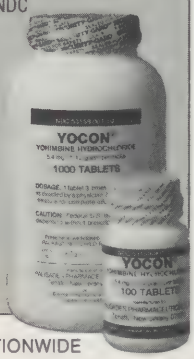
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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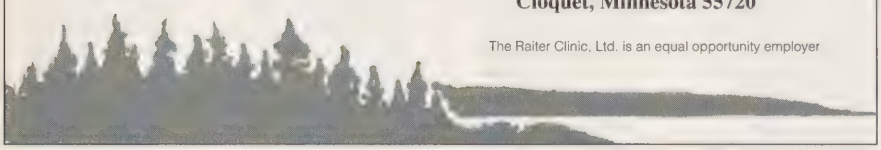


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* E. Paul Gieser, MD 034
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* Thomas A. Malec, MD 106
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* G. Robert Miller, MD 070
* Hubert Miller, MD 174
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* Steven A. Myers, MD 122
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Ronald D. Nervig, MD 070
* Robert L. Newhouse, MD 070
* Robert Niccolini, MD 222
* Robert G. Niven, MD 174
* Edward A. Nol, MD 174
Anne F. Norgan, MD 034
Ellen C. Norton, MD 106
* G. S. O'Sullivan, MD 034
* David J. Olen, MD 174
* Karin E. Olson, MD 070
* Romuald J. Orlowski, MD 098
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* Charles B. Overbey, MD 102
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* Roger C. Sider, MD 106
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* Peter T. Smith, MD 022
M. Duane Sommerness, MD 070
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* Marvin L. Starman, MD 174
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Linda M. Waldman, MD 222

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Albert A. Wallaert, MD 126
Julius M. Wallner, MD 218
* Denis E. Walsh, MD 218
Max W. Warren, MD 222
Richard D. Watkins, MD 170
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* Sander M. Weckstein, MD 070
* Howard Weiner, MD 218
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* Donald H. Williams, MD 090
* John R. Wittekindt, MD 102
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* Thomas C. Zelnick, MD 218
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Dale D. J. Chodos, MD 102
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Abhay V. Mehendale, MD 222
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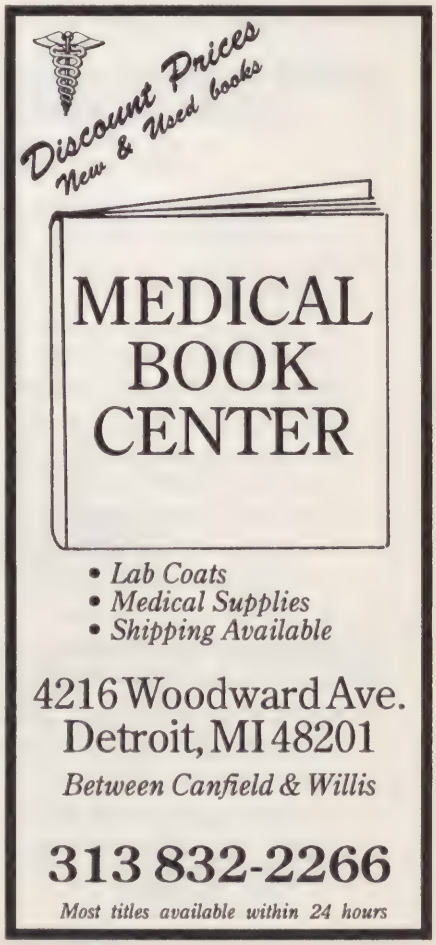
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* Carmel L. Davy, MD 106
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* W. C. De Mendonconca, MD 090
* Barry L. De Witt, MD 062
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* Rodrigo Diaz-Perez, MD 218
* Richard V. Dieterle, MD 098
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* Paul W. Gikas, MD 218
* Paul L. Ginther, MD 190
Alvaro A. Giraldo-Gomez, MD 222
Daniel F. Glaser, MD 102
Robert T. Goldman, MD 222
* Fernando C. Gomez, MD 186
* Paul A. Goodman, MD 174
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* Neelam B. Kumar, MD	222
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* Rosser L. Mainwaring, MD	222
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* Thomas F. Mc Cormick, MD	222
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* Willys F. Mueller, MD	062
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* Siamak A. Rahimi, MD	186
* Usha B. Raju, MD	222
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PUD – Pulmonary Diseases

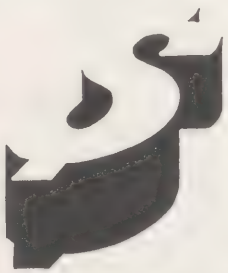
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* Libby S. Anderson, MD	098
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* Frankju A. Arevalo, MD	222
Robert M. Armbruster, MD	062
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* Arthur J. Bady, MD	222
* Kyoung S. Bae, MD	222
Robert B. Baker, MD	042
* Kirk G. Banerian, MD	062
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* Donald R. Bryant, MD	062
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* Maureen E. Forrest, MD 218
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* Zarina I. Galaria, MD 222
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James Gamero, MD 222
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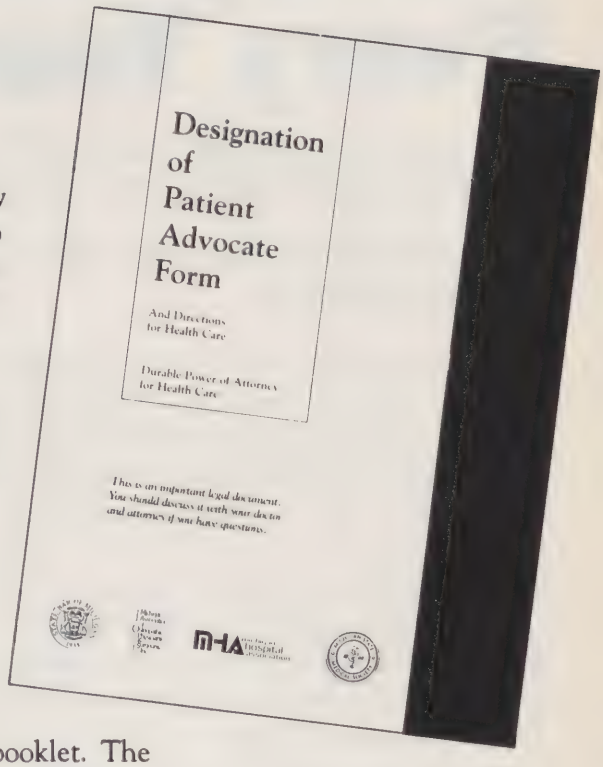
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Abbott Press ..... Kalifa Bofaris
AIDS Provider Education Project ..... Tracy Baker
AMA Delegation ..... Judy Marr
Annual Scientific Meeting Program ..... Lori Randall
BCBSM/Third Party Payors ..... Mary Anne Ford
Board of Medicine ..... Greg Aronin
Continuing Medical Education Accreditation ..... Sarah Cressman
MSMS-Sponsored Conferences/Seminars ..... Lori Randall
Dues Billing & Payments, Membership Records ..... Kathy Hagen
Federal Legislation ..... Kevin Kelly
Graduate Medical Education ..... Sherry Fent
Group Health Insurance Plan ..... Valerie Barker
Health Care Reform (Health Access America) ..... Mary Anne Ford
Health Data Research ..... Julie Lester
Health Education Foundation ..... Dawn Reha
HMOs/PPOs ..... Mary Anne Ford
Hospital Medical Staff Relations ..... Tom Plasman
International Medical Graduates ..... Betty McNerney
Judicial Commission ..... Sherry Fent
Legislation ..... Sandra Bitonti
Maternal Health Conference ..... Sarah Cressman
Media Relations ..... David Fox
Medicaid ..... Tom Wolff
Medical Assistants ..... Caroline Kimmel
Medical Billing Consulting ..... Joyce Nurenberg
Medical Ethics ..... Helen Fordham
Medical Students ..... Deborah Zannoth
Medicare Payment Reform ..... Julie Lester
Medigram ..... Claudia Skutar
Member Benefits/Recruitment ..... Deborah Zannoth
Michigan Allergy Society ..... Viola Heins
Michigan Association of Medical Education ..... Viola Heins
Michigan Chapter, American College of Obstetricians & Gynecologists ..... Viola Heins
Michigan Dermatological Society ..... Dawn Reha
Michigan Doctors Political Action Committee ..... Sandra Bitonti
Michigan Chapter, American College of Surgeons ..... Viola Heins
Michigan Medical Group Managers Association ..... Caroline Kimmel
Michigan Medicine (Journal) Advertising/Editorial ..... Betty McNerney
Michigan Society of Anesthesiologists ..... Caroline Kimmel
Michigan Society of Internal Medicine ..... Caroline Kimmel
Michigan Society of General Surgeons ..... Caroline Kimmel
Michigan Society of Pathologists ..... Viola Heins
Michigan Society of Respiratory Care ..... Caroline Kimmel
MPRO Ombudsman ..... Tom Plasman
National Practitioners Data Bank Ombudsman ..... Tom Plasman
MSMS Auxiliary ..... Dawn Reha
MSMS House of Delegates ..... Donna Farougi
MSMS Travel Programs ..... Donna Farougi
Physicians Communication Network ..... Helen Fordham
Physicians Contracting Assistance ..... Tom Wolff
Physicians Executive Organization ..... Tom Plasman
Physician Hospital Organizations ..... Tom Plasman
Physicians Recovery Network ..... Tom Wolff
Physicians Review Organization of Michigan, Inc. ..... Jim Tarrant
Physicians Legislative Network ..... Greg Aronin
Physician Service Group, Inc. ..... John Richards/Dawn Reha
Physician Well-Being Programs ..... Sherry Fent
Practice Management ..... Julie Smith
Professional Liability ..... Sandra Bitonti
Public Health Liaison ..... Tom Wolff
Public Relations/Public Service ..... Judy Marr
Regulation Compliance ..... Tom Wolff
Reimbursement Ombudsman ..... Joyce Nurenberg
Resident Physicians ..... Julie Lester
Risk Management ..... Julie Smith
Rural Health ..... Tom Plasman
Senior Courtesy Card ..... Tom Plasman
Specialty Societies ..... David Fox
Workers Compensation ..... Tom Wolff
Young Physicians ..... Deborah Zannoth

A Guide to MSMS Committees

MSMS has 43 committees and task forces which provide a platform for addressing issues ranging from aging to physician well-being. To effectively address such a wide range of issues, MSMS committees rely heavily upon member input. MSMS encourages involvement of as many different physicians as possible from every geographical area.

Committee appointments are awarded annually at the MSMS midsummer board of directors meeting held in July. Members are selected from a pool of applicants who have been nominated by current committee members, MSMS section officers and specialty and component society leaders. Committee appointments are for two-year terms, with new appointments taking place annually.

The first step toward obtaining a position, and the most difficult, is determining which committee (or committees) interests you most. A complete list of MSMS committees and task forces begins on this page. Each committee listing includes a brief statement of goals.

Members interested in serving on a committee must be appointed by the MSMS Board of Directors. Simply contact a current committee member, MSMS section leader, MSMS Board member, your county medical society or specialty society, or contact MSMS headquarters and request a recommendation. Each January MSMS begins seeking recommendations for committee appointments for the coming year. So now is a good time to start thinking about what committee you would like to join.

For more information on any of the MSMS committees, contact Jeanne Miller at MSMS.

Committee on Aging

This Committee provides physicians with an overview of the medical, social and psychological needs of the aged patient. Activities include examining the health status of the older patient, advocating preventative medicine programs, discussing Medicare financing, and exploring long-term care options for the elderly. The Committee works with many community organizations and the Michigan Office of Services to the Aging.

James G. O'Brien, MD
Lansing
Chairman

Archie W. Bedell, MD, Mt. Clemens
Frank S. Blumenthal, MD, Detroit
R. Jack Chase, MD, Grand Rapids
Willis L. Dixon, MD, Grand Rapids
Frederick W. Fitzpatrick, MD, Detroit
David P. Gage, MD, Saginaw
Martha L. Gray, MD, Ann Arbor
Eyassu Habte-Gabr, MD, Flint
Charles J. Heyka, MD, Petoskey
Raymond D. Hobbs, MD, Quincey
Daya P. Joshi, MD, Livonia
Richard A. Knecht, MD, Petoskey
Madelon H. Krissoff, MD, Grand Rapids
Daniel E. Leb, MD, Bloomfield Hills
Linda J. Logsdon, MD, Franklin
James C. Maher, MD, Marshall
Brooker L. Masters, MD, Fremont
Carl H. Moberg, MD, Grand Rapids
Joan P. Price, MD, Detroit
Sudhaker Rao, MD, Detroit
Randolph E. Schumacher, MD, Flint
Ashok R. Sonnad, MD, Vestaburg
John F. Strandmark, MD, Haslett
David W. Torkelson, MD, Saginaw
Robert J. Toteff, MD, Troy
Sanford Izenson, MPH, Consultant, Lansing
Eugene J. Napolitan, Consultant, Ann Arbor
John Peterson, PhD, Consultant, Lansing
Richard D. Yerian, DO, Consultant, Lansing
F. B. "Tom" Plasman, *Staff*

Committee on MSMS Archives

This Committee researches and retains a record of Michigan medical history so it will be preserved for future generations.

Frederick W. Bryant, MD
Troy
Chairman
Ned I. Chalat, MD, Detroit
William E. Madigan, ex officio, East Lansing
David K. Fox, *Staff*

Task Force on AIDS Education

This Task Force develops strategies for educating physicians about AIDS and coordinates MSMS efforts in physician and public education with those of the Michigan Department of Public Health.

David B. Martin, MD
Traverse City
Chairman

Robert D. Allaben, MD, Gaylord
Isak O. Berker, MD, Lapeer
Frederick W. Bryant, MD, Troy
Peter B. Campbell, MD, Flint
David S. Davenport, MD, Kalamazoo
Hugh G. Deery, II, MD, Petoskey
David J. Dobbie, MD, Grand Rapids
John F. Fennessey, MD, Grosse Pointe
Frederick W. Fitzpatrick, MD, Detroit
Daniel H. Havlichek, MD, Lansing
David M. C. Hislop, MD, Port Huron
Cecil R. Jonas, MD, Southfield
Donald W. Lawrenchuk, MD, Livonia
Douglas A. Mack, MD, Grand Rapids
Cathie Martin, Traverse City
Willys F. Mueller, Jr., MD, Fenton
David R. Rovner, MD, East Lansing
Richard M. Tooker, MD, Kalamazoo
Randall D. Pope, MDPH Representative, Lansing
Tracy A. Baker, *Staff*

Committee on Awards

This Committee supervises the MSMS awards program and makes recommendations to the Board of Directors.

Billy Ben Baumann, MD
Pontiac
Chairman

Henry M. Domzalski, MD, Detroit
Thomas C. Payne, MD, East Lansing
Katie Brewbaker, *Staff*

Committee on Bioethics

This Committee considers questions about scientific, medical, moral, ethical and political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and, therefore, MSMS.

Howard A. Brody, MD
East Lansing
Chairman

Isak O. Berker, MD, Lapeer
Michael J. Brennan, MD, Grosse Pointe Shores
John R. Caldwell, MD, Birmingham
Ralph D. Cushing, MD, Grosse Pointe
Betty Drew, Bloomfield Hills
James L. Fenton, MD, Bay City
Reginald W. Harnett, MD, Grosse Pointe Park
John V. Hartline, MD, Kalamazoo
Francis A. Horvath, MD, Lansing
Harm Kraai, MD, Pontiac
Philip M. Margolis, MD, Ann Arbor
Karen Maupin, Grand Rapids
Richard J. McMurray, MD, Flint
Butchi B. Paidipaty, MD, Farmington Hills
John Popovich, Jr., MD, Detroit
Emiliana L. San Diego, MD, Grand Rapids
John W. Tauscher, MD, Flint
Kornelius Van Goor, MD, Grand Rapids
Siavosh Varjavandi, MD, Flint
James E. Waun, MD, East Lansing
William B. Weil, Jr., MD, East Lansing
Fred W. Whitehouse, MD, Detroit

Eugene B. Lascu, Consultant, Berkley
Peter A. Levine, Consultant, Flint
Helen A. Fordham, *Staff*

Liaison Committee with Blue Cross Blue Shield of Michigan

This Liaison Committee serves as a communication link to assist individual physicians in obtaining information concerning Blue Cross Blue Shield of Michigan's policies and procedures, and provides input to aid in the resolution of problems which may arise. The Committee also considers and provides input on major policy and professional issues related to BCBSM.

Gary D. Maynard, MD
Kalamazoo
Chairman

Susan H. Adelman, MD, Detroit
Hassan Amirikia, MD, Detroit
John E. Billi, MD, Ann Arbor
Robert W. Black, MD, Grosse Pointe
Gilbert B. Bluhm, MD, Troy
Robert B. Borchak, MD, East Detroit
Robert L. Bree, MD, Ann Arbor
A. Joseph Brough, MD, Detroit
Carlo A. Dall'Olmo, MD, Flint
David A. Detrisac, MD, East Lansing
Manuel A. Echandi, MD, Flint
Douglas A. Edema, MD, Grand Rapids
Mark D. Kolins, MD, Troy
Paul A. Lafia, MD, Flint
R. Ralph Margulis, MD, Troy
Michael G. McCue, MD, Bingham Farms
Donald B. Muenk, MD, Warren
J. Scott Nystrom, MD, Harper Woods
Richard A. Pittsley, MD, East Lansing
Charles J. Poposki, MD, Ludington
Richard L. Rapport, MD, Flint
Daniel J. Reddy, MD, Detroit
John C. Rienstra, MD, Grand Rapids
Earl J. Rudner, MD, Southfield
Rahul B. Sangal, MD, Troy
John D. Schaldenbrand, MD, Ann Arbor
Jack M. Shartsis, MD, Warren
Sheldon N. Siegel, MD, Rochester Hills
Willard S. Stawski, MD, Grand Rapids
William J. Vandenbelt, MD, Bay City
Kirit K. Vora, MD, Troy
Lacey Walke, MD, Warren
Stanley B. Wolfe, MD, Bloomfield Hills
Michael A. Zerbini, MD, Pontiac
Peter A. Levine, Consultant, Flint
Eric P. Thompson, Consultant, Petoskey
Mary Anne Ford, *Staff*

Committee on Communications and Professional Relations

This Committee develops and oversees all professional/public relations and public service activities. It provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

W. Archibald Piper, MD
Flint
Chairman

Robert C. Arends, MD, Birmingham
David D. Bogarad, MD, Detroit
Henry M. Domzalski, MD, Detroit
Fereshteh Fahimi, MD, Lansing
Clyde R. Flory, Jr., MD, Lansing
Janet Gregory, Traverse City
Raymond R. Komray, MD, Muskegon
Blanche Mindlin, Bloomfield Hills
Fred E. Patterson, MD, Ann Arbor
Bernhardt L. Pederson, MD, Bay City
M. Gary Robertson, MD, Grand Haven
John Boyer, MD, Consultant, Detroit
Judith E. Marr, *Staff*

Committee on Constitution and Bylaws

Steven E. Newman, MD
Southfield
Chairman

R. Paul Clodfelder, MD, Grand Rapids
Angel Farina, MD, Garden City
Jack D. Gift, MD, Jackson
Thomas F. Higby, MD, Fowlerville
Samuel D. Indenbaum, MD, Birmingham
William E. Madigan, ex officio, East Lansing
Geoffrey A. Wardwell, MD, Kalamazoo
Richard D. Weber, Consultant, Detroit
Sherry L. Fent, *Staff*

Committee on CME Accreditation

This Committee assures that quality CME activities are available to Michigan physicians through review, evaluation, and accreditation of Category I continuing medical education providers in the state.

Robert L. Tupper, MD
Grand Rapids
Chairman

Donald J. Aiken, MD, Traverse City
George E. Bacon, MD, Grand Rapids
Robert O. Bollinger, PhD, Detroit
Ralph L. Brandt, MD, Tecumseh
James C. Breneman, MD, Galesburg
Allen D. Damschroder, MD, Petoskey
Norbert B. Enzer, MD, East Lansing
Mark I. Evans, MD, Detroit
Ved Gossain, MD, East Lansing
Ernest M. Hammel, PhD, Southfield
Roland G. Hiss, MD, Ann Arbor
Van O. Keeler, MD, Allegan
Paula J. Kim, MD, Grosse Pointe
David J. Millard, MD, Paw Paw
Robert K. Richards, PhD, Ada
Jan Rival, MD, Bloomfield Hills
David A. Rivera, MD, Lansing
Victor V. Rozas, MD, Alma
Robert W. Rosenbaum, MD, Saginaw
Richard F. Willis, MD, Alpena
Charles L. Zeller, MD, Kalamazoo
Thomas Noyle, Consultant, Midland
Sarah I. Cressman, *Staff*

Committee on CME Programming

This Committee develops, conducts, and supervises Category I programs in Michigan to serve the continuing medical education needs and interest of physicians. It also is empowered to jointly sponsor programs which meet the CME criteria for Category I.

David R. Rovner, MD
East Lansing
Chairman

Tama D. Abel, MD, Ann Arbor
John R. Addy, MD, Lansing
Rudi Ansbacher, MD, Ann Arbor
Frederick W. Bryant, MD, Troy
Clyde R. Flory, Jr., MD, Lansing
Michael J. Giacalone, Jr., MD, Grand Blanc
Dorothy Kahkonen, MD, Detroit
David J. Millard, MD, Paw Paw
Steven E. Minnick, MD, Detroit
Conrad E. Nagle, MD, Troy
John B. O'Donnell, MD, Grand Rapids
Shirley Robertson, MD, Mason
Joan C. Stryker, MD, Detroit
Virgilio Villarreal, MD, Flint
Lori S. Randall, *Staff*

Steering Committee on Program to Assist Impaired Physicians

This Steering Committee provides assistance, through its medical director and a statewide network of volunteer physicians, to physicians who have problems related to alcoholism, chemical dependency, emotional illness, physician impairment, and serves as the advisory body to the Physicians Recovery Network. Education and research toward prevention, case finding, and intervention are major components of the program.

Robert Niccolini, MD
Warren
Chairman

Frederick W. Bald, III, MD, Kalamazoo
Steven A. Bendix, MD, West Bloomfield
Steven H. Berger, MD, Grand Rapids
Michael Boyle, DO, West Bloomfield
David C. Dunstone, MD, Kalamazoo
Allan M. Ebert, DO, Flint
David B. Edgar, MD, Grand Rapids
James L. Fenton, MD, Bay City
Morris Fineman, DO, Livonia
James P. Gallagher, MD, Allen Park
Charles F. Gehrke, MD, Ypsilanti
Rosalind E. Griffin, MD, Southfield
George P. Harris, MD, Saginaw
Thomas L. Haynes, MD, Grand Rapids
Beverly Jensen, East Grand Rapids
Thomas Kane, DO, Berkley
John E. Kurtz, MD, Saline
Douglas W. Macdonald, MD, Clarkston
Jeffrey A. Meer, MD, Southfield
Richard A. Morin, MD, Ann Arbor
Paul H. Musson, MD, Flint
Eugene Sands, DO, West Bloomfield
Joan H. Shapiro, MD, Farmington Hills
James D. Stamp, MD, Canton
J. G. Steigerwald, DO, Traverse City
Gerald A. Vander Voord, MD, East Lansing
Michael L. Zarr, MD, Flint
Mary Mac Dowell, Consultant, Lansing
Jarl Nischan, Consultant, Lansing
Richard D. Weber, Consultant, Detroit
Katie Brewbaker, *Staff*

Committee on Maternal and Perinatal Health

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal, perinatal, and neonatal health to discuss mutual problems and share ideas. It works in close cooperation with the state agencies and medical specialty organizations.

Joseph S. Moore, MD
Grand Rapids
Chairman

Jody Lee Alexander, MD, Ypsilanti
Rudi Ansbacher, MD, Ann Arbor
Delores F. Baker, MD, Southfield

Mary P. Bedard, MD, Detroit
Ronald T. Burkman, MD, Birmingham
David R. Calver, MD, Bloomfield Hills
David B. Cotton, MD, Detroit
Robert W. Dustin, MD, Bloomfield Hills
Gerhard C. Endler, MD, Grosse Pointe Woods
James W. Gell, MD, Bloomfield Hills
Robert H. Hayashi, MD, Ann Arbor
John Hebert, III, MD, Flint
David M. C. Hislop, MD, Port Huron
Lloyd A. Kammeraad, MD, Grand Rapids
George M. Kazzi, MD, Grosse Pointe Shores
Nadya J. Kazzi, MD, Grosse Pointe Shores
Ratnaker K. Kini, MD, Birmingham
Chang Y. Lee, MD, Flint
Robert P. Lorenz, MD, Royal Oak
Federico G. Mariona, MD, Dearborn
Charles W. Newton, III, MD, Grand Rapids
Bernhardt L. Pederson, MD, Bay City
Roger W. Postmus, MD, Ypsilanti
C. Maureen, Sander, MD, East Lansing
David B. Schwartz, MD, Detroit
Richard H. Smith, MD, Detroit
Robert J. Sokol, MD, Bloomfield Hills
Arthur A. Ulmer, MD, Grosse Pointe Shores
Paul T. von Oeyen, MD, Royal Oak
George H. Baker, MD, Consultant, Lansing
Mary M. Conklin, RN, Consultant, Lansing
George W. Russian, DO, Consultant, Okemos
Mary A. Scoblic, RN, Consultant, Lansing
Richard Yerian, DO, Consultant, Lansing
Thomas M. Wolff, *Staff*

Advisory Committee to Section on Medical Economics

This Advisory Committee assists MSMS in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing and health delivery systems.

Fred E. Patterson, MD
Ann Arbor
Chairman

Asir U. Ahmad, MD, Pontiac
Steven R. Baker, MD, Grand Rapids
John H. Beernink, MD, Grand Rapids
Joseph J. Berke, MD, Detroit
Gilbert B. Bluhm, MD, Troy
Brooks F. Bock, MD, Detroit
M. Joseph Bowler, MD, Kalamazoo
Frederick B. Brown, MD, Muskegon
Ralph Cash, MD, Southfield
Thomas F. Curtin, MD, East Jordan
Hugh G. Deery, II, MD, Petoskey
James R. Dolan, MD, Kalamazoo
Jay W. Eastman, MD, Birmingham
Charles A. Easton, MD, Petoskey
Douglas A. Edema, MD, Grand Rapids
Paul O. Farr, MD, Grand Rapids
Gregory J. Forzley, MD, Grand Rapids
George R. Gerber, MD, Detroit
Floyd G. Goodman, MD, Lansing
Geoffrey R. Grambau, MD, Kalamazoo
John V. Hartline, MD, Kalamazoo
D. Bonta Hiscoe, MD, East Lansing
Samuel D. Indenbaum, MD, Birmingham
Edward G. Jankowski, MD, Clinton Twp.
Martin F. Jones, MD, Lansing
Daya P. Joshi, MD, Livonia
John C. Kirkpatrick, MD, Sturgis
Ruben S. Kurnetz, MD, Birmingham
John B. Lange, MD, Holland
Stanley H. Levy, MD, Detroit
AppaRao Mukkamala, MD, Flint
Steven E. Newman, MD, Southfield
Harold Perry, MD, Detroit
Sol D. Pickard, MD, Detroit
Edward J. Rutkowski, MD, Traverse City
Fred R. Severyn, MD, Detroit
Charles L. Shabino, MD, Kalamazoo
Jayant I. Shah, MD, Mt. Clemens
Frederick W. Sherrin, MD, Flint
Donald C. Smith, MD, Ann Arbor
David A. Strahle, MD, Flint
Robert M. Williams, MD, Harbor Springs
Larry J. Wurm, Consultant, Cadillac
Mary Anne Ford, *Staff*

Task Force on Rural Health Care

The Task Force gathers information on the increasing challenges of change occurring in rural health care and helps physicians make the necessary practice changes so that they may continue to provide quality health care to rural Michigan residents.

Michael J. Parks, MD
South Haven
Chairman

Douglas L. Colberg, MD, Colon
Kevin M. Fickenscher, MD, Kalamazoo
David H. Gilbert, MD, Laurium
Clark Herrington, MD, Bad Axe
James E. Jacques, MD, Tawas City
Tom M. Johnson, MD, East Lansing
William G. Keating, MD, Hillsdale
Steven R. Lessens, MD, Shelby
Louis E. Sanford, MD, Belding
Donald N. Schwing, MD, Manistee
Timothy J. Tobolic, MD, Byron Center
F. B. "Tom" Plasman, *Staff*

Liaison Committee with Michigan Peer Review Organization (MPRO)

This Liaison Committee monitors the activities of the federal peer review organization in Michigan (MPRO), provides policy input to MPRO on medical and operational issues, meets with MPRO representatives to discuss matters of mutual interest, and assists individual physicians in dealing with problems or concerns they may have with MPRO.

Robert C. Packer, MD
Muskegon
Chairman

Thomas F. Anderson, MD, Ann Arbor
Joseph A. Arena, Jr., MD, Madison Heights
Michael C. Boucree, MD, Flint
Lionel E. Dorfman, MD, Battle Creek
Gerhard C. Endler, MD, Grosse Pointe Woods
William R. Engelman, MD, Saginaw
Peter E. Fujiwara, MD, Bay City
Ronald N. Horowitz, MD, East Lansing
David K. Johnson, MD, Lansing
Daniel D. Joseph, MD, Onekama
Omar Kadro, MD, Royal Oak
Donald H. Kuiper, MD, Lansing
Ivan R. Landan, MD, Spring Lake
James C. Leisen, MD, Detroit
Michael J. Macksood, DO, Flint
Gary D. Maynard, MD, Kalamazoo
S. R. Nair, MD, Monroe
D. V. Ramana, MD, Davison
L. N. Swamy, MD, Ishpeming
Frederick W. Van Duyne, MD, Swartz Creek
Gordon F. VanOtteren, MD, Grand Rapids
William A. Willoughby, MD, Detroit
Francis M. Wilson, MD, Detroit
Samir R. Yahia, MD, Detroit
F. B. "Tom" Plasman, *Staff*

Planning Committee for MSMS Conference on Maternal and Perinatal Health

This Planning Committee plans and implements the Category I CME program for the Annual MSMS Conference on Maternal and Perinatal Health, in cooperation with several other participating organizations.

David R. Calver, MD
Bloomfield Hills
Co-Chairman

David Sciamanna, DO
Petoskey
Co-Chairman

John R. Addy, MD, Lansing
John M. Battle, MD, Plymouth
Mary M. Conklin, RN, Lansing
Steven M. Donn, MD, Ann Arbor
Molly Gates, RN, Chelsea
Sandra Geller, RN, Lansing
John V. Hartline, MD, Kalamazoo
Sandra Hayes, RN, Stevensville
Joy Herschberger, RN, Grand Blanc
Kate Larkin, RN, Troy
Judy Lindsey, RN, Grand Rapids
Federico G. Mariona, MD, Dearborn
Marybeth Meijer, RN, Grand Rapids
Joseph S. Moore, MD, Grand Rapids
Evelyn Piehl, RN, Ann Arbor
Shirley Robertson, MD, Mason
David B. Schwartz, MD, Detroit
Mary A. Scoblic, RN, Lansing
Suzanne Shelton, RN, Kalamazoo
Roberto Villegas, Jr., MD, Flint
Charles C. Vincent, MD, Detroit
Paul T. von Oeyen, MD, Royal Oak
Sarah I. Cressman, *Staff*

Planning Committee for MSMS Annual Scientific Meeting

This Planning Committee, under the guidance of the Committee on CME Programming, plans and presents Category I Credit courses at the Annual Scientific Meeting. It provides CME courses of value to all specialties while striving to improve methods of education and evaluation.

Dorothy Kahkonen, MD
Detroit
Chairman

Tama D. Abel, MD, Ann Arbor
Rudi Ansbacher, MD, Ann Arbor
Deloris A. Berrien-Jones, MD, Taylor
Frederick W. Bryant, MD, Troy
Miriam S. Daly, MD, Albion
Jeffrey H. DeClaire, MD, Rochester Hills
Nicholas J. Lekas, MD, Dearborn
David J. Millard, MD, Paw Paw
Kamran S. Moghissi, MD, Detroit
Mohammad Mohsenian, MD, East Lansing
Conrad E. Nagle, MD, Troy
Butchi B. Paidipaty, MD, Livonia
Joan C. Stryker, MD, Detroit
Greg Ott, Consultant, Ann Arbor
Lori S. Randall, *Staff*

Hagadorn, Inc.

Leland E. Holly, II, MD
Whitehall
Chairman

Jack L. Barry, MD, Bay City
Thomas R. Berglund, MD, Portage
William B. Cheeseman, East Lansing
William E. Madigan, East Lansing
Thomas C. Payne, MD, East Lansing
Warren F. Tryloff, Hamilton, Ohio
Richard D. Weber, Detroit

Board of Directors, Physician's Review Organization of Michigan

Robert C. Prophater, MD
Bay City
President

Robert W. Black, MD, Detroit
William E. Madigan, East Lansing
Marsha Milburn, MD, Lansing
Robert C. Packer, MD, Muskegon
Richard L. Rapport, MD, Flint
Donald C. Smith, MD, Ann Arbor
Willard S. Stawski, MD, Grand Rapids
Floyd C. Stevens, MD, Auburn
William Stevenson, Farmington Hills
Robert Stomel, DO, Farmington Hills
Jerome F. Trahan, East Lansing

Board of Directors, Physician Service Group, Inc.

Billy Ben Baumann, MD
Pontiac
President

Frederick W. Bryant, MD, Troy
Henry M. Domzalski, MD, Detroit
Elizabeth A. Hutchinson, MD, Lansing
Mark D. Kolins, MD, Grosse Pointe Farms
William E. Madigan, East Lansing
John A. Richards, East Lansing
David R. Rider, East Lansing
Allen F. Turcke, MD, Flint

Board of Directors, Group Insurance Trust

B. David Wilson, MD
Kalamazoo
Chairman

Jack L. Barry, MD, Bay City
Billy Ben Baumann, MD, Pontiac
Henry M. Domzalski, MD, Detroit
M. David Hislop, MD, Port Huron
William E. Madigan, East Lansing
W. Peter McCabe, MD, Grosse Pointe Woods
Earl G. Moehn, MD, Mt. Clemens
John A. Richards, East Lansing
David R. Rider, East Lansing
B. David Wilson, MD, Kalamazoo

Board of Directors, Abbott Press

Billy Ben Baumann, MD
Pontiac
Chairman

Jack L. Barry, MD, Bay City
Robert C. Prophater, MD, Bay City
William E. Madigan, East Lansing
B. David Wilson, MD, Kalamazoo
Henry M. Domzalski, MD, Detroit
Earl G. Moehn, Mt. Clemens
John A. Richards, *Staff*

Task Force on Professional Liability

This Task Force reviews the professional liability climate in Michigan and the nation, is familiar with proposed reforms, and recommends appropriate legislative or other improvements.

Thomas E. Stone, MD
Muskegon
Chairman

S. Akram Ali, MD, Port Huron
Hassan Amirikia, MD, Detroit
Firooz Banooni, MD, Southfield
Rajendra Bothra, MD, Warren
Lawrence E. Briski, MD, Detroit
Lois Duhamel, Rochester
Peter A. Duhamel, MD, Rochester
Chandra M. Edwin, MD, Detroit
Domenic R. Federico, MD, Grand Rapids
Geoffrey R. Grambau, MD, Kalamazoo
D. Bonta Hiscoe, MD, East Lansing
Beverly Jensen, East Grand Rapids
Lloyd A. Kammeraad, MD, Grand Rapids
W. Peter McCabe, MD, Grosse Pointe Woods
Frederick V. Minkow, MD, Bloomfield Hills
Steven E. Olchowski, MD, St. Clair Shores
Thomas C. Payne, MD, East Lansing
B. L. Pederson, MD, Bay City
David A. Rivera, MD, Lansing
Mark S. Roth, MD, Ann Arbor
Charles K. Safley, MD, Flint
Gregory D. Shannon, MD, Flint
John L. Shek, MD, Saginaw
Marjorie C. Treadwell, MD, Grosse Ile
Michael C. Tomlanovich, MD, Detroit
Narenda S. Tyagi, MD, Waterford
Arthur A. Ulmer, MD, Grosse Pointe Shores
Ralph F. Woodbury, MD, St. Clair Shores
Peter A. Levine, Consultant, Flint
Jan Maskell, Consultant, Grand Rapids
Kathleen Maslanka, Consultant, Detroit
Mary Sue Meyer, Consultant, Birmingham
Richard D. Weber, Consultant, Detroit
Thomas M. Wolff, *Staff*

Medicaid Liaison Committee

This Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

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Yvonne M. Friday, MD, Detroit
Shobha S. Gehani, MD, Detroit
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Charles C. Vincent, MD, Detroit
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Thomas M. Wolff, *Staff*

Committee on Medical Licensure and Discipline

This Committee serves as a liaison to the Michigan Department of Commerce's Bureau of Occupational and Professional Relations and the Michigan Board of Medicine, and seeks and supports measures that will promote a fully effective Board of Medicine.

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Norman J. Rotter, MD, Dearborn
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Committee on Membership and Recruitment

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to the Board of Directors and conducts personal recruiting efforts when needed.

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Sue Van Tuinen, Grand Rapids
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Peter Levine, Consultant, Flint
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Mary Sue Meyer, Consultant, Birmingham
Sallie J. Shiel, Consultant, Ann Arbor
Michael Thomas, Consultant, Detroit
Deborah Zannoth, *Staff*

Liaison Committee with Michigan Department of Public Health

This Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concerns.

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Committee on Federal Legislation

This Committee monitors and influences federal legislation, and rules and regulations in conjunction with the AMA Washington office.

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Committee on Specialty Societies

This Committee provides for regular communication between MSMS and the members of specialty organizations. It deals with any subject of mutual concern except scientific or clinical medicine.

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MSMS/Michigan Hospital Association Liaison Committee

This formal Liaison Committee is composed of designated leaders of the two organizations. The Liaison Committee does not make policy for either organization; each organization refers any recommendations to the MSMS Board of Directors or MHA Board of Trustees for approval.

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Interprofessional Committee with State Bar of Michigan

This Liaison Committee promotes interprofes-sional cooperation, helps mediate problems between physicians and attorneys, and encourages communication on topics of mutual interest.

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Robert D. Burton, MD, Grand Rapids
Alexa Canady, MD, Detroit
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Steven E. Newman, MD, Southfield
Thomas C. Payne, MD, East Lansing
Richard D. Weber, Detroit

Committee on State Legislation and Regulations

This Committee monitors and influences Michigan legislation related to health care and responds to government rules and regulations promulgated by the State. The Committee works to enhance physician participation in the state legislative process.

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Troy
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Robert G. Borchak, MD, East Detroit
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Dennis Muchmore, Consultant, Lansing
Richard D. Weber, Consultant, Detroit
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Committee on Concerns of Women Physicians

This Committee explores ways to encourage the participation and leadership involvement of women physicians in organized medicine.

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Cynthia C. Cohen, MD, Taylor
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Conchita Riparip, MD, Saginaw
Marguerite R. Shearer, MD, Ann Arbor
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Honor M. Wolfe, MD, Detroit
Eva L. Youshock, MD, Rochester Hills
Stacy A. Kohmetscher, *Staff*

Task Force on Environment and Health

This Committee educates physicians, the public and state government regulators about the effects of the environment on human health; to develop MSMS policy on environmental issues; and to identify MSMS members with interest and expertise in environmental issues and the human health effects of environmental hazards.

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Mary Anne Ford, *Staff*

MSMS/MPMLC Risk Management Committtee

The Michigan State Medical Society Section of Risk Management was developed with the support of Michigan Physicians Mutual Liability Company (MPMLC) to increase MSMS member involvement in the planning and implementation of risk management activities. This section has two main objectives. The first is to increase the number of risk management education programs available for physicians and related health care professionals, and to coordinate programs to insure that their content meets the needs and desires of the MSMS members. A second objective of the section is to inventory practice parameter development with Michigan and coordinate the involvement of Michigan physicians in practice parameter related projects. The purpose of the Risk Management Committee is to oversee the activities of the section and to provide assistance and guidance as necessary.

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Marguerite Shearer, MD, Ann Arbor
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Task Force On Physician Well-Being

This Task Force has been formed to plan and help implement an MSMS educational program for physicians which focuses on professional well-being. The mission of such a program is to teach self-care skills to physicians so they and their families can cope with the kinds of stress unique to the medical professional. The educational goal is to promote the health of physicians and their families, to help them avoid impairment so they can continue to care for their patients. The Task Force includes representatives from the MSMS Board, MSMS Auxiliary, specialty societies and county medical societies.

Carl F. Hammerstrom, MD
Marquette
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Lois Duhamel, Rochester
David C. Dunstone, MD, Kalamazoo
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Sherry L. Fent, *Staff*

County Medical Societies have close ties with MSMS Board, staff

Every county medical society is represented on the MSMS Board of Directors or by one or more elected physicians, depending on the size of that group's membership. In addition, an MSMS staff member is assigned as liaison and resource person to each county society. The contact persons are indicated below.

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County Medical Society Executives

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Fax: (616) 468-5858

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Fax: (313) 238-3782

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Margo Hoornstra, Exec Dir
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East Lansing, MI 48823
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Fax: (517) 337-2490

JACKSON COUNTY MEDICAL SOCIETY
Richard Ambs, Exec Dir
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Jackson, MI 49204
Phone: (517) 784-5682
Fax; (517) 787-8636

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Mary A. Agar, Exec Sec'y
433 S. Rose Street
Kalamazoo, MI 49006
Phone: (616) 342-8502

KENT COUNTY MEDICAL SOCIETY
Chip McClimans, Exec Dir
220 Cherry Street SE
Grand Rapids, MI 49503
Phone: (616) 458-4157
Fax: (616) 458-3305

MACOMB COUNTY MEDICAL SOCIETY
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Fax: (313) 225-0115

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These Brochures Currently Available Through MSMS

ORDER FORM

The following brochures are currently available through the Michigan State Medical Society

Qty

___ **"Physician's Guide To Michigan Law and Medical Practice Resources"**
A 106-page reference outlining the statutes and regulations which affect the practice of medicine in Michigan. First copy is free to MSMS members and any additional copies are $35.00. They are $95.00 for non-members.

___ **"Bloodborne Pathogens & Right To Know"**
A physician's guide to MIOSHA regulations. First copy is free, with a charge of $1.00 per additional copy.

___ **"Michigan's Durable Power of Attorney for Health Care -- A Complete Guide for Physicians"** (free)
This is a special supplement to *Michigan Medicine* regarding the Patient Advocate Act of 1990. It includes the actual Designation of Patient Advocate Form and also a special guide for physicians from MSMS Legal Counsel.

___ **"1993 Michigan State Medical Society Priorities"** (free)
This publication lists the top priorities of MSMS and gives a brief description of each.

___ **"What You Should Know About Your Health Care Insurance"** (50-100 @ $.20 each; 101-500 @ $.18 each; 501+ @ $.15 each)
This informative and helpful brochure includes a checklist of questions for patients to consider before choosing a health care insurer.

___ **"If You Have Questions...Ask Your Physician" Poster** (free)
A bright blue poster encouraging patients to ask their doctors any questions they may have about symptoms, diagnosis, treatment, prescriptions and insurance. Ideal for placement in physician waiting rooms.

___ **"You & Your Doctor - Working Together for Quality Medical Care"** (one free sample, additional copies @ $.20 each)
This informative booklet is designed to help patients choose and evaluate a doctor and explains how physicians keep up with medical progress.

Qty

___ ***Michigan Medicine* and *Medigram*** (subscription to members - free; life/retired members $50 for both; subscription to non-members - $100 per year for both publications or $50 per year for *Medigram* only)
Michigan Medicine, the official journal of the Michigan State Medical Society is published monthly and *Medigram*, our newsletter is published weekly.

___ **"Michigan's Medical Liability Crisis"** (free)
This pamphlet outlines Michigan's Medical Liability Crisis and the package of bills currently in state legislature to create reforms. It also includes many current facts and figures on this crucial issue.

___ **"If Someone in Your Family Wants to Become a Doctor"** (50 copies free--additional copies $.15 ea)
This brochure is designed for those who are exploring the occupation of a physician. It gives a brief explanation of the medical training required of physicians and clarifies a few basic medical terms.

___ **"Continuing Medical Education Requirements for Physicians Licensed by the Michigan Board of Medicine"** (free)
This booklet is meant to assist physicians in fulfilling the continuing medical education requirement by clarifying Michigan's mandate.

___ **"Break the Silence"** (free)
This pamphlet promotes the MSMS joint effort with the Michigan State Bar and the Michigan Hospital Association to inform the public of the vital need for organ and tissue donations.

___ **"Disability Duration Guide"** (free)
This booklet is intended to assist physicians involved in employee disability cases. It will also help medical professionals, corporate medical directors, insurance companies and employers assess appropriate disability lengths.

___ **"3 Great Reasons to Join MSMS"** (free)
This brochure gives the physician three of the most significant reasons to join MSMS.

___ **"Your County Society, Your State Society, Your AMA -- Working Together"** (free)
This brochure briefly describes the benefits of memberships with your county and state medical societies, and also with the American Medical Association.

Qty

___ **"MSMS Headquarters"** (free)
This is a brochure describing major MSMS activities with a map to the East Lansing Headquarters.

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MSMS 1993 Calendar Seminars & Conferences

JANUARY

Medical Biller Training Series (Medicaid)

January 7-8 Pretzel Bell, East Lansing

How to Effectively Handle Workers' Compensation Claims

January 26 Holiday Inn, Flint
January 27 Best Western Domino Farms, Ann Arbor
January 28 WMU Regional Center, Grand Rapids

Orientation to the Medical Office

January 28-29 MSMS Headquarters, East Lansing

FEBRUARY

Winter Risk Management Conference

February 2-6 Keystone Resort, Colorado

Medical Biller Training Series (Other Carriers)

February 4-5 Pretzel Bell, East Lansing

MSMS/BCBSM Medicare Update

February 9 Novi Hilton, Novi
February 10 Treasure Island, Saginaw
February 16 Grand Traverse Resort, Traverse City

How to Comply with CLIA Regulations

February 16 Troy Marriott, Troy
February 17 Lansing Center, Lansing
February 18 Treasure Island, Saginaw

Risk Management: Closed Claim Reviews (Family Practice)

February 17 Sylvan Resort, Gaylord
February 18 Treasure Island, Saginaw
February 23 Novi Hilton, Novi
February 25 WMU Regional Center, Grand Rapids
February 26 MSMS Headquarters, East Lansing

Becoming an Exceptional Biller

February 18-19 Novi Hilton, Novi

Improved Collection Practices in the Health Care Office

February 22 Westin Hotel, Detroit
February 23 Michigan Athletic Club, East Lansing
February 25 Grand Traverse Resort, Traverse City

Professional Well-Being Workshop

February 25 Holiday Inn University Place, East Lansing

MARCH

Carcinoma of the Breast: A National Liability Epidemic

March 3-5 Shanty Creek, Bellaire

Risk Management Communications Conference

March 5-7 Shanty Creek, Bellaire

Risk Management: Closed Claim Reviews (Anesthesiology)

March 9 Novi Hilton, Novi
March 10 Sylvan Resort, Gaylord
March 11 Treasure Island, Saginaw
March 18 MSMS Headquarters, East Lansing
March 30 WMU Regional Center, Grand Rapids

Providing Outstanding Patient Service

March 9 Treasure Island, Saginaw
March 10 Best Western Domino Farms, Ann Arbor
March 11 WMU Regional Center, Grand Rapids

Improving Physician Image: How Do You Communicate Caring?

March 12 Radisson on the Lake, Ypsilanti

Accent Management Workshop

March 12 Radisson on the Lake, Ypsilanti

Supervisory Skills Series - Part I (Master the Principles of Office Supervision)

March 16 Wayne County Medical Society, Detroit
March 17 Holiday Inn, Flint
March 18 Fetzer Center, Kalamazoo

Fundamentals of Risk Management

March 16 WMU Regional Center, Grand Rapids
March 18 Wayne County Medical Society, Detroit
March 23 Holiday Inn South, Lansing

Medical Biller Training Series (Blue Cross/Blue Shield)

March 18-19 Novi Hilton, Novi

Maternal and Perinatal Health Conference

March 24-25 Holiday Inn South, Lansing

Risk Management: Closed Claim Reviews (OB/GYN)

March 24 Holiday Inn South, East Lansing

Coding Clinics for Specialties

March 25	Holiday Inn South, Lansing (OB/GYN)
March 30	Hotel Baronette, Novi (Anesthesiology/ General Surgery)
March 31	Treasure Island, Saginaw (Anesthesiology/General Surgery)

Risk Management: Closed Claim Reviews (Psychiatry)

March 31	Sylvan Resort, Gaylord

APRIL

Making the Best of Hospital/Physician Relations

April 1	Sheraton Oaks, Novi

Orientation to the Medical Office

April 1-2	WMU Regional Center, Grand Rapids

Electronic Billing: Do You Know All You Need to Know?

April 6	Grand Traverse Resort, Traverse City
April 7	Troy Marriott, Troy
April 8	WMU Regional Center, Grand Rapids

Risk Management: Closed Claim Reviews (Psychiatry)

April 7	Treasure Island, Saginaw
April 8	Novi Hilton, Novi
April 14	WMU Regional Center, Grand Rapids
April 15	MSMS Headquarters, East Lansing

CME Accreditation Conference

April 8	Michigan Athletic Club, East Lansing

Medical Biller Training Series (Medicare)

April 12-13	Novi Hilton, Novi

Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide

April 13	Fetzer Center, Kalamazoo

Opportunities 1993: An Array of Medical Practice Opportunities for Michigan Physicians

April 15	Detroit

Professional Well-Being Workshop

April 22	Holiday Inn, Flint

Supervisory Skills Series- Part II (How to Deal With Difficult People and Situations)

April 20	Holiday Inn, Flint
April 21	Michigan Athletic Club, East Lansing
April 22	Hotel Baronette, Novi

Risk Management: Closed Claim Reviews (Pathology)

April 20	Sylvan Resort, Gaylord
April 21	Treasure Island, Saginaw
April 22	Novi Hilton, Novi
April 27	MSMS Headquarters, East Lansing

Coding Clinics for Specialties

April 27	WMU Regional Center, Grand Rapids (Radiology/Primary Care)
April 28	Holiday Inn, Flint (Radiology/Primary Care)

Future Vision: Physicians in the Year 2002

April 29	Ritz Carlton, Dearborn

MAY

Coding Clinics for Specialties

May 3	WMU Regional Center, Grand Rapids (Anesthesiology/General Surgery)
May 4	Hotel Baronette, Novi (Radiology/ Primary Care)

Opportunities 1993: An Array of Medical Practice Opportunities for Michigan Physicians

May 10	WMU Regional Center, Grand Rapids
May 13	Best Western Domino Farms, Ann Arbor

Risk Management: Closed Claim Reviews (Pathology)

May 11	WMU Regional Center, Grand Rapids

Risk Management: Closed Claim Reviews (Cardiology)

May 12	Sylvan Resort, Gaylord
May 13	Treasure Island, Saginaw
May 18	Novi Hilton, Novi
May 19	WMU Regional Center, Grand Rapids
May 20	MSMS Headquarters, East Lansing

Becoming an Exceptional Biller

May 17-18	Grand Traverse Resort, Traverse City

Medical Office Management Institute

May 17-21	Radisson on the Lake, Ypsilanti

Orientation to the Medical Office

May 20-21	Westin Hotel, Detroit

Electronic Billing: Do You Know All You Need to Know?

May 25	Ritz Carlton, Dearborn
May 26	Treasure Island, Saginaw
May 27	Fetzer Center, Kalamazoo

Maternal Health Conference Retreat

May 27-28 Northern Resort

JUNE

Carcinoma of the Breast: A National Liability Epidemic

June 1 Novi Hilton, Novi
June 2 WMU Regional Center, Grand Rapids

Improving Your Practice Productivity and Performance in the 1990's

June 1 Troy Marriott, Troy
June 2 Treasure Island, Saginaw
June 3 Fetzer Center, Kalamazoo

Supervisory Skills Series- Part III (How to Build an Effective Office Team)

June 8 Best Western Domino Farms, Ann Arbor
June 9 Treasure Island, Saginaw
June 11 Sylvan Resort, Gaylord

MSMS Financial Planning Series

- Financial Planning for Retirement (June 11)
- Early Financial Planning for Physicians (June 12-13)

June 11-13 Sylvan Resort, Gaylord

Medical Biller Training Series (Blue Cross/Blue Shield)

June 14-15 Grand Traverse Resort, Traverse City

MSMS/AMA Young Physicians Series

- Joining a Partnership or Group Practice (June 24)
- Starting Your Medical Practice (June 25-26)

June 24-26 Radisson on the Lake, Ypsilanti

JULY

Professional Well-Being: The First Step in Providing Care to Others

July 9-12 Boyne Highlands, Boyne City

Medical Biller Training Series (Medicare)

July 21-22 Grand Traverse Resort, Traverse City

Orientation to the Medical Office

July 22-23 MSMS Headquarters, East Lansing

AUGUST

Medical Biller Training Series (Medicaid)

August 9-10 Park Place Hotel, Traverse City

Medical Office Management Institute

August 16-20 Grand Traverse Resort, Traverse City

Becoming an Exceptional Biller

August 26-27 Sheraton Inn, Lansing

Enhancing the Value of Your Practice

August 27-29 Grand Hotel, Mackinac Island

SEPTEMBER

Medical Biller Training Series (Other Carriers)

September 1-2 Grand Traverse Resort, Traverse City

Supervisory Skills Series- Part IV (Maximize Your Time, Energy and Brainpower)

September 8 Troy Marriott, Troy
September 9 Fetzer Center, Kalamazoo
September 10 WMU Regional Center, Grand Rapids

Risk Management: Closed Claim Reviews (Orthopedic Surgery)

September 9 WMU Regional Center, Grand Rapids
September 14 Sylvan Resort, Gaylord
September 15 Treasure Island, Saginaw
September 23 Novi Hilton, Novi
September 28 MSMS Headquarters, East Lansing

Medical Biller Training Series (Blue Cross/Blue Shield)

September 13-14 Michigan Athletic Club, East Lansing

Diagnosis and Management of Myocardial Infarction

September 15 Grand Traverse Resort, Traverse City
September 22 Novi Hilton, Novi
September 23 WMU Regional Center, Grand Rapids

Fundamentals of Risk Management

September 21 Holiday Inn, Marquette

Orientation to the Medical Office

September 23-24 MSMS Headquarters, East Lansing

MSMS Regulatory Conference

September 28 Troy Marriott, Troy

Risk Management: Closed Claim Reviews (OB/GYN)

September 29 WMU Regional Center, Grand Rapids
September 30 Sylvan Resort, Gaylord

OCTOBER

Providing Outstanding Patient Service

October 5 Grand Traverse Resort, Traverse City
October 6 Fetzer Center, Kalamazoo
October 7 Troy Marriott, Troy

Risk Management: Closed Claim Reviews (OB/GYN)

October 5	Treasure Island, Saginaw
October 6	Novi Hilton, Novi
October 7	MSMS Headquarters, East Lansing

Patient Education Conference

October 13	Michigan Athletic Club, East Lansing

Risk Management: Closed Claim Reviews (Ophthalmology)

October 13	WMU Regional Center, Grand Rapids
October 14	Sylvan Resort, Gaylord
October 18	Treasure Island, Saginaw
October 19	MSMS Headquarters, East Lansing
October 27	Novi Hilton, Novi

Medical Biller Training Series (Medicare)

October 14-15	Michigan Athletic Club, East Lansing

The Exceptional Medical Assistant

October 18	Grand Traverse Resort, Traverse City
October 19	Fetzer Center, Kalamazoo
October 20	Hotel Baronette, Novi
October 21	Treasure Island, Saginaw
October 22	WMU Regional Center, Grand Rapids

Fundamentals of Risk Management

October 20	Grand Traverse Resort, Traverse City
October 21	Novi Hilton, Novi

*** *Plus*, Sports Medicine Conference**

October Date to be Announced, East Lansing

NOVEMBER

Colon and Prostate Cancer: Avoiding Two Common Malpractice Traps

November 3	WMU Regional Center, Grand Rapids
November 4	Novi Hilton, Novi

Medical Biller Training Series (Medicaid)

November 4-5	Novi Hilton, Novi

MSMS Annual Scientific Meeting

November 9-11	Westin Hotel, Detroit

Accent Management Workshop

November 11	Westin Hotel, Detroit

Fundamentals of Risk Management

November 16	Fetzer Center, Kalamazoo
November 17	Port Huron Hospital, Port Huron

Orientation to the Medical Office

November 18-19	Treasure Island, Saginaw

MSMS/BCBSM Medicare Update

November 30	Holiday Inn, Flint

DECEMBER

MSMS/BCBSM Medicare Update

December 1	Best Western Domino Farms, Ann Arbor
December 2	WMU Regional Center, Grand Rapids

Medical Biller Training Series (Other Carriers)

December 2-3	Novi Hilton, Novi

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FAMILY PRACTITIONERS/INTERNISTS - BC/BE - Saint John's Health Care Corporation, a member of the Holy Cross Health System, is a 371-bed facility in central Indiana. Saint John's was recognized by the JCAHO as a top 10% Quality Organization in the nation. Very competitive compensation and incentives are available to qualified physicians located in the Saint John's service area. Anderson, Indiana is a pleasant 60,000 resident community close to Indianapolis with the advantages of a major metropolitan area. Send CV or contact Steven Pavik, Director, Medical Staff Affairs, Saint John's Health Care Corporation, 2015 Jackson Street, Anderson, Indiana 46016, (317) 646-8303.

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EMERGENCY PHYSICIAN: Port Huron area. Low volume 10,000 to 12,000 annual visits. Twelve hour shifts. Salary or hourly. Send C.V. to Mr. Joseph L. Romain, 18161 West 13 Mile Road, Suite A-2, Southfield, MI 48076 or call (313) 642-9878.

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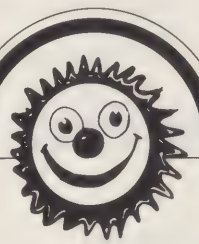
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CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosponne, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC_{0-12hr} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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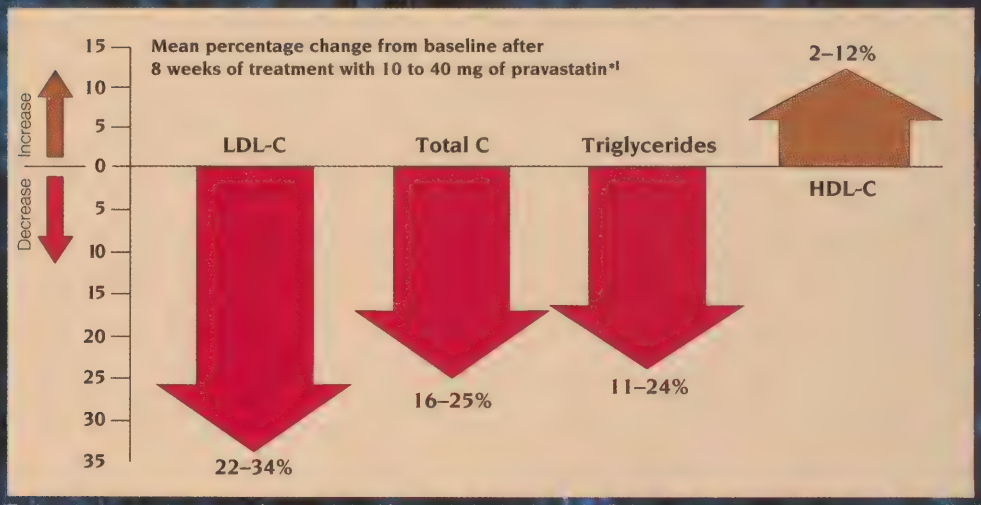
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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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FEBRUARY 1993
VOL. 92, NO. 2

Award-Winning Journal of the Michigan State Medical Society

Cover Story

Physician Image

There's plenty you can do to enhance your image...now and in the future

Assisted Suicide:

What impact will the state's new law have on medical practice?

Physician Hospital Organizations:

A viable option for physicians

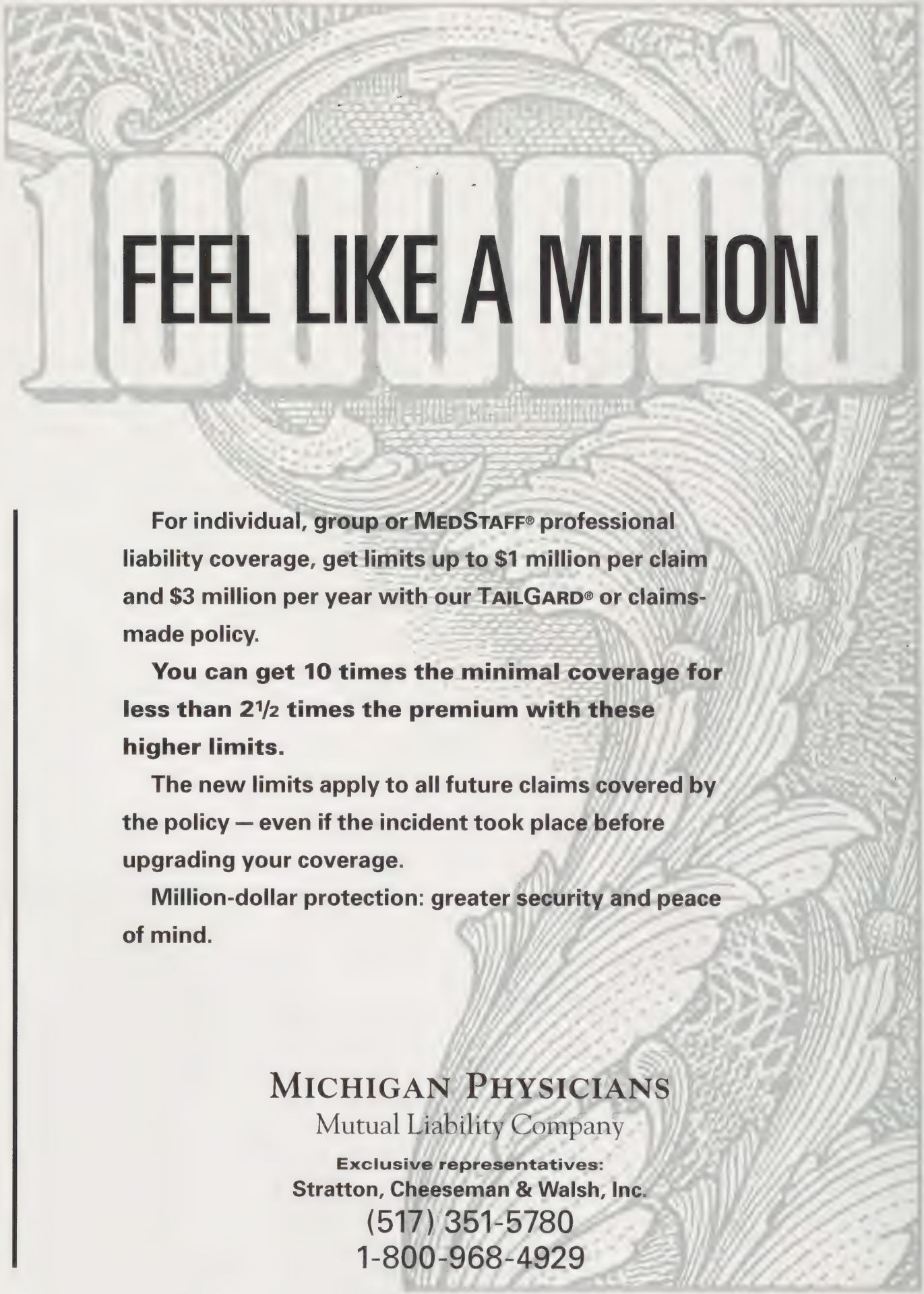
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- Physician profile: Oliver D.W. Grin, MD
- Soundoff!
- MSMS on the Move
- Reimbursement Roundup



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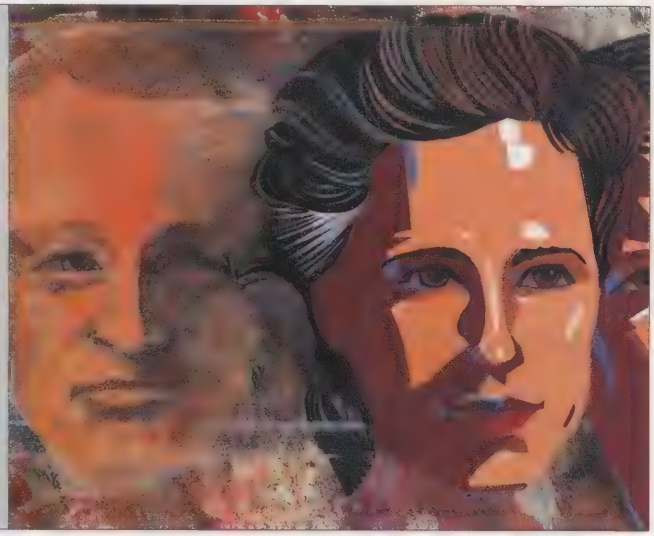
MICHIGAN MEDICINE

FEBRUARY 1993 VOLUME 92, NO. 2

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

When MSMS conducted a series of focus groups last fall as part of its "Medicine in the Year 2002" project, one message about physician image was made loud and clear: physician image is the one thing that is entirely in physicians' hands. The prescription for building a positive image, according to those polled: communication, communication, communication. Physicians need to communicate with their patients and for them, too, in the legislative arena and elsewhere. Included in this month's cover story are suggestions and examples of activities physicians may undertake to help make a positive statement both for themselves and for the medical profession.



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Legislative Ban on Assisted Suicide

This indepth feature includes an examination by Howard Brody, MD, of the impact of Michigan's recent legislative ban on assisted suicide on medical practice. Also included are comments by Oakland County Prosecutor Richard Thompson, who says this legislation will provide more protection for physicians, not less. Rounding out this feature is an opinion by MSMS Legal Counsel Richard D. Weber.

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Physician Hospital Organizations

PHOs are already providing flexible and futuristic responses for hospitals and physicians in Michigan. Included in this feature is an examination of the evolutionary process of physician/hospital joint venturing.

By Monte Jahnke

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Physician Profile: Oliver D.W. Grin, MD

After a 30-year journey by sea, this Grand Rapids neurosurgeon discovered his roots. At age 50, he's beginning a new life.

By David K. Fox

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In next month's issue:
Public Health Issues

Cover illustration: *By Robert L. Brent*

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Michigan Medicine (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published once each month, 12 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $100.00 (includes weekly *Medigram* newsletter); single copies, $3.00: Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news and exchanges should be addressed to Betty McNerney, advertising to Pat Horan, and address changes to Kathy Hagen, Michigan State Medical Society, P.O. Box 950, East Lansing, Michigan 48826-0950. Phone 517-337-1351.

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SOUNDOFF!

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If you think malpractice is bad...

By Eugene B. Becker, MD, JD

Three health care professionals have recently been convicted of a crime for which they may be sentenced to spend years in jail. They thought they were law abiding citizens simply acting within the scope of their professional interest. They never tried to hide what they were doing, and they didn't believe they were committing a serious crime.

These are the facts of their crime: In 1988 almost all of the dentists in Tucson, Arizona participated in each of several dental plans. The plan payments had not been increased in ten years, so that payments for some procedures did not even cover expenses. Individual dentists had protested without effect.

The dentists were angry and frustrated. Finally, they held a group meeting in the office of Doctor A. L. Alston to discuss fees. At the meeting each dentist was given two letters. One of the letters was a form letter to the insurance company saying, in effect, "I'm not going to stand for this anymore." The other letter was from Doctor Alston urging each dentist to sign and mail the first letter. Many of the dentists did mail off the protest letters, and after receiving the letters the insurance companies did revise their fee schedules.

The story set out above states all of the elements of the crime for which Doctors Alston, Meyer, and Walker were convicted. They appealed their convictions. The process has taken more than three years of legal maneuvering. It probably has cost the defendants more than one hundred thousand dollars in legal fees which is not covered by malpractice insurance. As of mid-November of this year the dentists still remain under threat of jail.

The law under which the dentists were convicted is section 1 of the Sherman Anti-Trust Act. That section declares any contract, combination, or conspiracy in restraint of trade to be illegal, and this case should be a warning to physicians. Doctors who practice as members of a partnership may discuss fees with their partners. But doctors should not engage in any kind of collective action without having first obtained legal advice.

To bring the story up to date, the trial judge contrasted the treatment of the dentists with the treatment accorded a group of lawyers who had engaged in similar conduct. At about the same time the dentists in Tucson were committing their crime, the lawyers of Washington, D.C. had taken an even more aggressive group action in a fee matter. The lawyers acted in concert to force the D. C. government to raise the fees paid to them for defending indigent defendants. Although this was also a violation of section 1 of the Sherman Anti-Trust Act, the lawyers of the United States Justice Department did not choose to bring a criminal prosecution against their D.C. lawyer

Continued on following page

Continued from page 5

colleagues. It was left to the Federal Trade Commission to bring a civil complaint which was probably settled for a reprimand and a token fine.

After contrasting the treatment of the dentists and the lawyers, and for other reasons, the trial judge granted a new trial to Doctor Alston and granted judgments of acquittal to Doctors Meyer and Walker. The Justice Department appealed, and the appellate court ruled that "the law is the law." It was within the discretion of the trial court to grant a new trial to Doctor Alston, but the appeal court required that Doctors Meyer and Walker also should be retried.

The legal fees in connection with the new trial already are mounting. The Justice Department has not yet decided whether to reprosecute in new trials, so the dentists are left to contemplate going through the whole thing all over again. They also are left with the threat of possible criminal conviction and a jail sentence.

The lesson here is worth repeating: Doctors who practice as members of a partnership may discuss fees with their partners. But doctors should not otherwise discuss fees with their colleagues. And doctors should not engage in any kind of collective action without having first obtained legal advice.

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LETTERS

Don't get caught without your computer backup

Recently, I realized that you never know if something works unless you or someone else has used it. In October, a doctor's office in Michigan burned to the ground. The doctor stopped by recently and thanked us for insisting that they back up their computer system every night. He realized that without the backup of their computer system, he would have lost everything. Their most recent backup tape was in the office manager's purse.

We restored everything from their backup tape on the day after the fire. Now they are reconstructing pertinent patient record data from their patient ledgers. Patient appointments and recall data also are being recovered from their computer. Their backup worked.

A doctor in Jackson told me that they regularly do their backups and put the backup tape in a safe. Although the safe might protect the paper documents from burning, the intense heat will destroy the backup tape.

Backup tapes or diskettes that are left in the office will only protect from temporary computer hardware losses. The backup tape or diskettes must be taken out of the office. Do not get caught without your backup!

Gerry Schmidt
Sales Manager
Colonial Valley Software, Inc.
Flint

Parkinson's Disease: Another Treatment Tool, The Michigan Parkinson Foundation

Parkinson's Disease (PD) is a debilitating neurological disorder producing slow, poorly coordinated bodily movements, tremor, muscular rigidity, loss of balance and, often, dementia and/or depression. It afflicts approximately one percent of people over the age of 60 and, as our population ages, the numbers of patients requiring care, and families needing support, will continue to grow.

Despite the major advances in drug treatment, e.g., L-dopa (Sinemet), various dopamine agonists (Parlodel, Permax) and other medications, (Eldepryl, anti-cholinergic), the need for more effective treatment remains. Patients have more complex management problems including needs for assessment and treatment related to major performance (physical therapy canes, walkers, wheelchairs, etc.) cognitive and emotional issues (psychopharmacology and psycho therapy and so on).

Patients and families often need the support and guidance that an organization such as the Michigan Parkinson Foundation (MPF) can provide.

The MPF provides programs of patient support through the Model Resource Center: it sponsors support groups throughout the state, it holds educational seminars, distributes a quarterly newsletter about Parkinson's, offers a host of printed materials and video tapes about Parkinson's treatment and supports students working on Parkinson's disease research. The educational materials can be of great value to patients, family and professionals.

Because of its large network of support groups, education and support are available to patients and caregivers around Michigan. In addition, MPF offers a toll-free information and answering service, which makes them as near as your phone (1-800-852-9781). Or you can call (313) 745-2000 to speak to someone directly.

I would like to encourage you to refer patients you believe could benefit from these MPF programs. The MPF can help patients and their families live the happier life we'd like them to have.

Jay M. Gorell, MD
Henry Ford Hospital

MSMS solicits support for tobacco-free school policy

Editor's note: The following is a letter MSMS recently sent to the Michigan Education Association to urge MEA support for a tobacco-free school policy.

The Michigan State Medical Society (MSMS) is writing to urge the Michigan Education Association (MEA) to support a tobacco-free school policy. Such a policy would prohibit the use of tobacco products in school buildings and vehicles and on school grounds by anyone at any time.

MSMS believes strongly that in order to have a future that is free of tobacco-related disease, we must begin by preventing tobacco use among our children. Teachers are extremely important role models for children, and thus should set a good example by not smoking on school grounds. It also is important to note that environmental tobacco smoke has been shown to be hazardous to the health of non-smokers who are exposed to it on a regular basis. Ventilation systems are often not adequate to clean recirculated air of environmental tobacco smoke.

MSMS is aware that the MEA has not supported state legislation that would require that all Michigan schools be smoke free on the grounds that this issue should be the subject of collective bargaining. We believe that your opposition to a state mandate imposes on your organization a moral obligation to address this issue through collective bargaining.

MSMS looks forward to working with you to advance the health and welfare of our children.

Thomas C. Payne, MD
MSMS President

Continued on following page

PHYSICIAN OPPORTUNITY

A Natural Selection

St. Luke's Healthcare Association – a progressive, multifacility healthcare system located in Saginaw, Michigan – currently has private practice and hospital career opportunities for physicians in selected areas of specialization.

The Association provides a complete range of specialty care units, including adult and pediatric intensive care, coronary care and emergency care. We recently opened The Family Birth Center™ – a progressive, new, single-room obstetrics unit. And we cooperate in an active residency program affiliated with Michigan State University's College of Human Medicine.

St. Luke's Healthcare Association is a diverse and growing organization, anxious to meet with physicians interested in pursuing a career marked by a strong administration/physician working relationship and a team approach to patient care.



If you're such a physician, St. Luke's Healthcare Association and Saginaw, Michigan, are natural selections. Contact us today for additional information.

Call or write Jan Gould,
Physician Recruiter:

St. Luke's Hospital
700 Cooper Ave.
Saginaw, MI 48602
1-800-633-3546.

StLukes

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Pension Plan Protection

Editor's note: The following is a letter sent to MSMS from MSMS legal counsel regarding pension plan protection.

As I advised you earlier this year, the United States Supreme Court in *Patterson v. Shumate* held that ERISA-qualified pension plan assets are protected from creditor claims in bankruptcy. In that case, the debtor was an executive of a company with multiple participants. Now the U.S. Supreme Court has applied this rule in the context of a single health care professional.

In *Reed v. Drummond*, the debtor was a physician and a sole shareholder of his professional corporation. He was also the trustee and sole beneficiary of the pension plan. He filed a voluntary petition under Chapter 7 of the Bankruptcy Code and claimed that his pension plan, then worth approximately $800,000, was exempt from his bankruptcy estate. The bankruptcy court disagreed, as did the district court and the Ninth Circuit. Based on the *Shumate* decision, the Supreme Court reversed and held that the ERISA-qualified plan assets were protected from creditor proceedings.

This case clearly indicates that the Supreme Court intends that the protection to ERISA-qualified plan assets apply not only to corporate retirement plans but also the plans established by individual physicians of small professional corporations where the debtor/physician is the only participant in the retirement plan.

Please call me if you have any further questions about this expected but significant ruling of the U.S. Supreme Court.

Richard D. Weber
Kerr, Russell and Weber

MSMS ON THE MOVE

A monthly update of key MSMS activities

Second MSMS joint section meeting coming next month

MSMS sections will conduct a joint meeting March 12-13 at the Radisson-On-The-Lake, Ypsilanti. It's the second such meeting. Prior to 1992, the MSMS sections for Hospital Medical Staffs, International Medical Graduates and Young Physicians held separate meetings.

Each section's governing council plans its own meeting the evening of March 12. A kick-off joint session for the sections is planned for March 13. Immediately following, each section will break out into its own session. AMA Board of Trustees member Randolph Smoak, MD, South Carolina, will be the keynote luncheon speaker for all attendees on Saturday. Each section is in the process of naming delegates and gathering resolutions for consideration at the meeting. Deadline for submitting resolutions is February 12. Contact Judy Marr at MSMS at (517) 336-5744 for more information.

MSMS Government Affairs Day chance to meet legislators

Physicians will get to meet and talk with Michigan legislators at the 1993 MSMS Government Affairs Day March 23. The daylong event will begin with a morning issues briefing session at the Lansing Civic Arena. Keynote speakers are Rep. Richard Bandstra (R-Grand Rapids) and Representative Pat Gagliardi (D-Drummond Island). Legislators and physicians will attend a special luncheon. Physicians then will head to the Capitol for tours and appointments with their legislators. Call Sandra Bitonti at MSMS at (517) 336-5737 for information.

MSMS maternal/perinatal health conference set for Lansing

Obstetrics and pediatrics will be the topics at hand during the 1993 MSMS Conference on Maternal and Perinatal Health March 24-25. This year's theme is "The Perinatal Challenge." Courses are set on infant mortality, family violence, exercise in pregnancy, trauma in pregnancy and other topics. The 32nd annual conference will be held in Lansing. Call Sarah Cressman at MSMS at (517) 336-5727 for details.

MSMS to educate seniors on 11 voluntary assignment programs

Hundreds of senior citizens will meet in Lansing May 20 this year, as they do every spring, for Senior Power Day. MSMS plans to set up an information booth at the Senior Power Day Consumer Fair to provide details on physician voluntary assignment programs created in 11 Michigan counties. Under the programs, participating physicians accept Medicare's reimbursement as payment in full for seniors who qualify.

MSMS this year will continue its work with physicians to set up similar programs in other Michigan counties.

For details on these and other issues call William E. Madigan, Executive Director, MSMS, 517/337-1351.

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MEDICAL NEWSFRONTS

Grant to create statewide trauma network

A one-year, $162,905 federal grant to reduce the number of trauma induced deaths and disabilities in Michigan has been awarded to the Michigan Trauma Coalition, and State Health Department under the National Trauma Systems Planning and Development Act. MTC, a private, non-profit organization of over 180 participating health facilities, medical schools, health associations, and individuals, is contributing $40,000 to the project.

"Trauma injuries are the fourth leading cause of death in Michigan after heart disease, cancer and stroke," says State Health Director Vernice Davis Anthony. "Most of these injuries are preventable and treatable. Our goal is to create a coordinated system of care that will enable us to quickly respond to trauma emergencies."

Michigan currently lacks a coordinated statewide trauma and emergency care treatment system. In states where such systems are in place, deaths and permanent injury due to trauma are reduced significantly. The Council of Injury Control estimates that more than 5,500 Michigan citizens die each year due to traumatic injuries. Another 3,150 suffer long-term, and often permanent disabilities as a result of such injuries. The combined social and economic cost of these casualties has been estimated at more than $1.5 billion per year.

Unlike traditional health planning efforts where proposals are generated by government health planners and then sent out for local provider review, Michigan's Trauma Systems Planning and Development Project will directly challenge trauma care providers to reach agreement on workable statewide trauma facility and trauma systems standards, triage and transfer protocols, and procedures for monitoring and evaluation. The technical development and consensus building activities will be undertaken by MTC; the health department will provide oversight and quarterly progress reviews as well as conduct hearings on the recommendations proposed by the Coalition.

U-M, Munson Medical Center to launch Alzheimer's clinic

Munson Medical Center and the Michigan Alzheimer's Disease Research Center at the University of Michigan have teamed up to create a new clinic offering the benefits of Alzheimer's research to patients in northern Michigan.

The Satellite Diagnostic and Treatment Clinic will be established in Traverse City in early 1993. The clinic will diagnose and treat approximately 50 patients annually who are suspected of having Alzheimer's disease and related disorders. Patients will see local physicians specially trained to offer sophisticated care and have the chance to participate in experimental drug studies.

Funded by a $130,000 grant from the National Institute of Aging, the SDTC supports the Michigan Department of Mental Health's efforts to provide a wider network of Alzheimer's diagnostic and treatment resources across the state. The center also will lead to better, more informative research by including rural population groups who are now underrepresented in studies. To complement the clinic, Munson also will launch a new Geriatric Assessment Clinic.

MPRO names new executive director

Jane Deane Clark, PhD, senior director of Michigan Hospital Association's Health Policy Analysis Division, has been named as the executive director of the Michigan Peer Review Organization's Center for Health Outcomes and Evaluation. In her new position, Clark will be responsible for the development of a Health Care Quality Improvement Initiative, as part of MPRO's Fourth Scope of Work contract with the federal government. During her seven years with MHA, Clark coordinated the data policy activities and the collection, publication, and dissemination of health care data for members. She also had responsibility for the association's activities relating to long-term care and served as the executive director of the Michigan Health Data Corporation.

Henry Ford receives more than $7.6 million for hypertension research

Henry Ford Hospital has been awarded more than $7.6 million dollars from the National Institutes of Health (NIH) to study the development of hypertension, vascular disease and congestive heart failure.

Led by Oscar Carretero, MD, division head of Hypertension and Vascular Research Division at Henry Ford Hospital, the study will investigate how the body regulates blood pressure and kidney function through the formation of local hormones.

New program aimed at reducing infant mortality in Detroit

A nearly $875,000 Michigan Department of Social Services grant to The Wellness Plan will fund establishment of a pregnancy clinic in one of Detroit's more impoverished areas (the lower east side). The objective is to demonstrate and evaluate methods of reduc-

Continued on following page

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ing perinatal mortality resulting from high risk pregnancies.

The program will be directed by N. S. Rangarajan, MD, in collaboration with Hutzel Hospital and the Department of OB/GYN at Wayne State University. The study will last two years and will involve 1,000 women who live in the target area, who are at 185 percent of the poverty level or below, and who are on Medicaid or are eligible for Medicaid due to their pregnancies.

Researchers looking for ways to help city kids breathe easier

Despite major advances in treatment methods, childhood deaths from asthma are steadily increasing, with inner-city black males at highest risk.

About three months ago, researchers at Henry Ford Hospital began recruiting participants for a multi-center study aimed at finding out why.

Henry Ford Hospital is one of eight institutions in the US participating in the National Cooperative Inner-City Asthma Study, funded by a grant from the National Institute of Allergy and Infectious Diseases (NIAID).

Researchers will consider a multitude of possible factors for the increased incidence of asthma among inner-city children, including access to health care, quality of health care, compliance with medical advice, living conditions, exposure to allergens and cultural attitudes toward health care.

Once the major factors contributing to the increased incidence of asthma are identified, the study centers will develop and implement therapeutic, educational and environmental programs to combat them.

Beaumont study finds short bouts of intense exercise are better at improving fitness

One hour of exercise, three times a week, has long been considered the standard for achieving heart and lung fitness.

But a study by William Beaumont Hospital researchers shows that young "couch potatoes" can get fit with as little as **11 minutes** of high-intensity exercise, three times a week.

The Beaumont study involved 22 sedentary men under the age of 35, who were randomly assigned to a high or a low-intensity exercise regimen for six weeks. The high-intensity group averaged 11.7 minutes of progressively-difficult treadmill exercise (comparable to a cardiac stress test), three times a week. The low-intensity group averaged 50 minutes of mild to moderate forms of exercise (i.e. biking or walking at 70-85 percent of capacity), three times a week. Oxygen consumption was measured for each participant before and after the exercise training program.

Men in the high-intensity group showed a 17 percent improvement in oxygen consumption during treadmill testing, compared to a nine percent improvement for those in the low-intensity exercise group. When tested on a stationary bicycle, the high-intensity exercisers again outperformed the low-intensity group with a 15 percent improvement in oxygen consumption, versus an 11 percent improvement for low-intensity exercisers.

"Our study found that high-intensity, short duration exercisers achieved almost double the improvement in fitness, in one-quarter the time," explains Barry Franklin, PhD, Beaumont's Director of Cardiac Rehabilitation and Exercise Laboratories. "For young, healthy, sedentary people, short bouts of intense exercise are as effective as conventional exercise training in improving fitness, and possibly even more so."

Doctor Franklin cautions that the benefits of a short, high-intensity workout may not outweigh the risks for middle-aged and older people, or those with a history of heart disease. He recommends a more conventional training program, consisting of one hour of mild to moderate exercise, three times a week, for "couch potatoes" over age 30.

1-800 Get-Rehab launches campaign to increase awareness of medical rehabilitation

A recent broad national public opinion survey shows that over one-half (58 percent) of the general public is uninformed about medical rehabilitation, and that more than one-third (35 percent) of seriously ill patients - those with brain injury, stroke, amputation or birth defects - have not undergone medical rehabilitation because their physicians have not recommended it.

"These results confirm findings from an earlier survey we commissioned by the Gallup organization that indicated there is a real need for information about medical rehabilitation. That is why we have launched a major national education campaign about the benefits of medical rehabilitation," said Dale Eazell, chairman of the Medical Rehabilitation Education Foundation.

As part of this national education campaign, the Medical Rehabilitation Education Foundation has launched **1-800 GET-REHAB,** a 1-800 number where callers can obtain general information on medical rehabilitation and a referral service for help in locating rehabilitation facilities throughout the country.

The survey of 1,004 adults was conducted by The Wirthlin Group in October of 1992 to measure awareness levels regarding medical rehabilitation among the general public.

Other findings in the October 1992 survey included:

**Whether or not a person receives medical rehabilitation depends significantly on the physician's recommendation - for both serious and less serious conditions. As with the 1988 survey, the referring physician is most likely to be the family doctor in 68 percent of less serious and 72 percent of more serious cases.

**More than one-third (36 percent) of Americans with less serious injuries or conditions (chronic back or neck pain, mild to moderate arthritis, a sports injury, knee or hip replacement)

do not receive medical rehabilitation treatment. Of this group, 71 percent reported that their physician did not recommend treatment.

New association established for physician inventors

The American College of Physician Inventors proudly announces its incorporation with the motto "Creatrix Medicus Pro Ingenio Suo Noscatur"/ Let the Creative Physician Inventor be Recognized for His Genius. This organization has been formed by a prestigious group of physician inventors to establish a forum for creative professionals and to assist in the inventing, patenting and marketing process of ideas applicable to the medical profession. The American College of Physician Inventors, Ridgewood, N.J., also acts as a liaison between physician inventors, the medical community, industry and the government regulatory agencies.

Membership in the American College of Physician Inventors is $95 dollars and includes a subscription to *CREATIVITY*, the publication of ACPI. In addition, membership brings inventors, experts and industry in contact with each other at their annual meeting. The College will conduct seminars on topics of special interest to the medical inventor including the latest technologies applicable to the medical field, the latest developments in patent law, how to commercialize an invention, raising capital and other topics of related interest.

Currently under development is a museum to house prototypes of inventions and to document the history of medicine through technological developments. This unique aspect of the college is very exciting and has provoked widespread interest. Doctor Rubin, as Provost, and his staff will be soliciting contributions to the museum from members as well as from historical societies and universities.

Membership is open to physicians who hold a patent. Affiliate membership is available on an interim basis to physicians with a patent pending. Non-physician inventors who hold patents applicable to the medical profession are also invited to join and can be granted membership with board approval. For further information and an application contact Frank Debernardis at 352 Hillcrest Road, Ridgewood, N.J. 07450, phone 201-447-6926 or Charles Klieman, MD, 12291 East Washington Blvd., Whittier, CA 90262 or phone 310-698-0271.

AMA'S 'Project USA' celebrates 20 years placing physicians in understaffed rural posts

When the US Government needs temporary physicians to cover the vacations or training of federal doctors, it looks to the American Medical Association and its *Project USA*, now in its 20th year.

The AMA opened its *Project USA* office in 1972. The project formalized AMA efforts to find and recruit temporary replacements for physicians serving in the National Health Service Corps, a federal medical program providing physicians to medically underserved rural communities.

In 1975 *Project USA* began offering the same benefits to the Indian Health Service, a federal corps providing health care to native Americans on Indian reservations.

Participants in the AMA program are usually primary care physicians, licensed in at least one state, able to give 2-4 weeks of service, and willing to work in a solo practice or small rural hospital. Typically young or semi-retired physicians, many spend their vacations with *Project USA*, at sites as varied as Virginia, New Mexico, the Dakotas, and Alaska's northern coast.

Project director John Naughton says that more women physicians are answering the call, anxious to help where there is acute medical need. Naughton describes project physicians as "dedicated, flexible people - many of them very highly regarded - often willing to come back year after year." In many cases, these physicians provide rural communities with more continuity of service than the communities receive from regular NHSC or IHS officers, who serve an obligated term in repayment of tuition assistance - and then may be gone.

Veteran project physician John M. Wagner, MD of Hillsville, Virginia, says the program gives him the opportunity "to assist people from all stations of life and to form satisfying relationships with consistently competent local staff." In Sisseton, SD, IHS staff physician Doctor Gary Gesualdi, MD, calls the AMA program "a real life-saver, helping us survive with gracious help from fine physicians, turning a (work force) crisis into something manageable."

At its inception, *Project USA* was providing the NHSC with 100 weeks of replacement physicians per year. In 1975, the project began providing an additional 100 weeks to the IHS. In 1992 - the AMA program's 20th anniversary year - *Project USA* has upped its annual NHSC coverage to 125 physician-weeks and its IHS coverage at 500 physician-weeks.

Naughton sees a growing need for *Project USA* physicians in years to come. He believes that - because of the professional and cultural opportunities it offers them - the program will continue to be a successful partnership, both for project physicians *and* for the communities they serve.

For more information on *Project USA*, call 312-464-4430.

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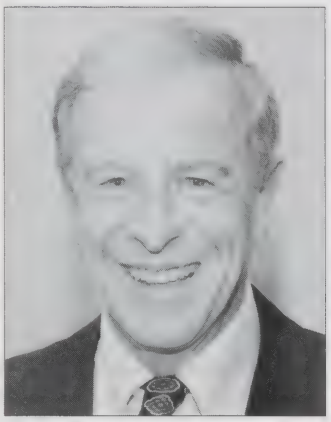
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PHYSICIANS IN THE NEWS



Robert D. Burton, MD,
is a member of the Board of Governors of the newly-formed University of Michigan Medical Center Alumni Society. Doctor Burton is one of a select group of physicians from across the country recently elected to serve on the Board for a three-year term. The U-M Medical School and Hospitals, and the School of Nursing are in the process of forming two distinct alumni societies. Among his first tasks as a member of the Board, Doctor Burton will examine a possible new committee structure for the Board and consider new alumni and alumni-student programming ideas. A Grand Rapids otolaryngologist, Doctor Burton is immediate past president of MSMS.

Lucius C. Tripp, MD,
is a newly-named member, Board of Directors, American College of Occupational and Environmental Medicine. Doctor Tripp is the group medical director for General Motors' Buick-Oldsmobile-Cadillac Divison and Detroit North Regional Medical Director.

John P. Papp, MD,
is a newly-named Master of the American College of Gastroenterology. Doctor Papp is head of the endoscopy unit at Blodgett Memorial Medical Center in Grand Rapids.

Richard Miller, MD, PhD,
is a newly-appointed member of the National Advisory Council on Aging. Doctor Miller is a professor in the department of pathology, University of Michigan Medical School.

Gene Ragland, MD,
is a member of the Board of Directors of the Domestic Violence Project, Washtenaw County. Doctor Ragland is currently president-elect of the Washtenaw County Medical Society.

Jai Prasad, MD,
is the newly-appointed medical director of the Detroit Receiving Burn Center. Doctor Prasad was formerly a director of the University of Michigan Burn Center and director of the Beyer Hospital burn unit.

Warren R. Mullen, MD,
is Pentwater's 1992 Citizen of the Year. Doctor Mullen served as Pentwater's only physician from 1953 until his retirement in 1980. He continues to practice part-time as an emergency physician at Memorial Medical Center.

Richard H. Walker, MD, and Herbert F. Polesky, MD,
are co-recipients of the "Ward Burdick Distinguished Service to Clinical Pathology" award from the American Society of Clinical Pathologists. Doctor Walker is chief of Beaumont's Blood Bank and Transfusion Service and also serves as a clinical professor at both Oakland University's School of Health Sciences and Wayne State University's School of Medicine. Doctor Polesky is chief of the Minneapolis Memorial Blood Center.

The Michigan Society of Internal Medicine
has elected the following officers for 1992-1993: President, Catherine Upton, MD; President-elect, Ronald VanderLaan, MD; Secretary-Treasurer, Ashok Gupta, MD. Doctor Upton is the first woman to be President of the Michigan Society of Internal Medicine.

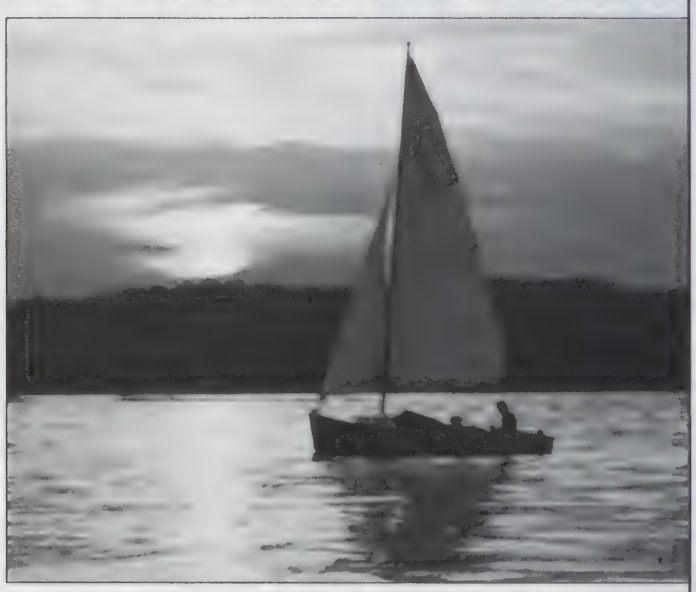
The Michigan Medical Group Management Association
has elected the following officers for 1992-1993: President, Brian T. Anderson, MD; President-Elect, Vivian M. Bellis, MD; 1st Vice-President, Marsha Bassett; Treasurer, Eric P. Thompson, MD; Secretary, Gary C. Paavola, MD.

Douglas L. Wood, DO,
is the new chairperson of the Certificate of Need Commission. Doctor Wood, dean of the Michigan State University College of Osteopathic Medicine, is the first physician appointed to the commission.









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Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS: Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy: Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE: Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992 5890

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MSMS Reimbursement Roundup

By Joyce Nurenberg
MSMS REIMBURSEMENT OMBUDSMAN

Better collection rates with a written and communicated plan

How do you rate the level of patient collections in your office? This is one of the questions that we ask physicians and office staff before an office consultation.

If you are not satisfied, it may be because you do not have a current, written and communicated plan that holds staff accountable to policies and procedures that promote successful collection practices.

You should examine your current credit and collection policies and procedures to determine if they reflect your best interests and personal attitude. By developing an organized plan for collections, you promote consistent methods of collection and prevent patient payments from becoming too old and costly to collect.

A comprehensive collection plan should include policies, procedures, standards and timetables for all collection actions, including patient and telephone contacts, patient statements, referrals to collection agents, insurance claim submission, and follow up. Your plan should include guidelines that address what to do when the patient can not pay in full at the time of service. To be sure that your collection plan complies with state and federal laws regarding credit and collections, it is wise to consult an attorney about your written plan.

Successful implementation of a collection plan requires organization and consistent application by each staff member. If you decide to change any part of your written plan, put the changes in writing to keep all items current. The plan should always be a resource for current staff, a training tool for new personnel and your guide to evaluating performance.

Follow these tips

The following additional tips will help you develop and implement a plan for patient collections.

- Encourage your staff to be part of the plan. Use staff meetings to brainstorm on solutions to patient situations or to discuss different collection methods that may be more useful in your office. Make sure each staff member understands his/her role in collection and the roles of other staff. Seminars on collections will help your staff recognize potential problem situations and improve their ability to administer your collection policies. You also can help by questioning potential employees on their attitudes and previous experience and by explaining your attitudes and policies to new employees.
- Be consistent. If payment is not made in full, obtain payment agreements from patients before they leave the office. Your office staff should suggest the payment standard and timetable.
- Have protocols in place for common situations, considering the payer mix in your office.
- Be aware of your office policies, so that you do not contradict them in conversations with the patient.
- Have the tools available that will help your patients understand your collection policy and help your staff implement your plan. Signs, patient brochures, reporting forms and collection technique data are valuable aids.
- Use reporting tools to help you evaluate the success of your plan. Aging analysis reports, which show your outstanding balances by age, payment plan agreements, daily logs showing patient payments and insurance payment vouchers all can help.

MSMS consultants can provide assistance with collection policies. Contact Joyce Nurenberg at (517) 336-5722 for more information.

Reimbursement Roundup addresses third party payor reimbursement issues affecting physician practices. Comments and problems brought to the attention of the Reimbursement Ombudsman are routinely shared with the Liaison Committee with Blue Cross and Blue Shield of Michigan and its Subcommittee on Medicare Carrier Problems.

Physician Image There's plenty you can do to enhance it...



Now and in the future

By Betty J. McNerney, Editor

When MSMS conducted a series of focus groups last fall as part of its "Medicine in the Year 2002" project, one message about physician image was made loud and clear: physician image is the one thing that is entirely in physicians' hands. "If we project our concern for the welfare of the public," said one physician, "they will respect us. If we project self-interest, they will not." The prescription for building a positive image, according to those polled: communication, communication, communication. Physicians need to communicate with their patients and for them, too, in the legislative arena and elsewhere. Included in this month's cover story are feature articles on two Michigan physicians: one who has developed a unique way to open the channels of communication with his patients; and one who has devoted countless hours to creating a healthy environment. Both kinds of activities reflect well on the individual physicians initiating them, and on the medical profession, as well. Additional opportunities to make a positive statement for medicine abound in the MSMS priorities list and the instructions for contacting legislators, which follow these physicians' personal stories. Take time to study these priorities carefully and then decide how you can become involved in making these goals a reality.

Cover Story

Patient education videos an excellent way to inform patients, avoid lawsuits.

They're also a great image-builder

By Helen Fordham



L. W. Fitzsimmons, MD

Here's how one Lansing orthopedic surgeon has successfully developed a series of educational videos for his patients.

Talk to any physician and he or she has a litany of horror stories about the dampening effects of malpractice lawsuits. They will tell you of the million-dollar payouts that have destroyed practices, demoralized physicians and driven high-risk specialties out of state.

One doctor so concerned about the liability climate in Michigan has decided to take things into his own hands. Instead of waiting for a patient to file a suit, Lansing orthopedic surgeon, L. W. Fitzsimmons, MD, has gone on the offensive and developed an innovative way of encouraging patients to take responsibility for their own health care.

"It's a hostile environment out there and it is important to deal with the risks up front," explains Doctor Fitzsimmons, who produces patient education videos. His videos outline the risks, complications and expected outcomes of procedures and explain the roles of the physician and patient.

"The tapes are designed to educate patients about their role and responsibilities in their own health care," says Doctor Fitzsimmons, who strongly believes that patient's lack understanding about their role in their own health care has led to the liability climate and has created the expectation that the physician is totally responsible for anything that occurs.

One of the primary sources of malpractice lawsuits is poor communication, according to Doctor Fitzsimmons, and he believes the videos, by clarifying the physician/patient relationship and inviting questions, help remove barriers to communication. To date, all efforts at enhancing communication have been aimed at physicians, not patients, says Doctor Fitzsimmons. Yet communication is a two-way street. "Physicians cannot be 100 percent responsible for communication," he says. "Patients also have a responsibility to ask questions if they don't understand."

> "It gives you more credibility having the patients see you on TV," he says. "Patients see you much more as an authority."

Communication analysis was not what Doctor Fitzsimmons had in mind four years ago when he was looking for a way to document that he educated his patients about their procedures. He contemplated videotaping interviews with his patients but decided that would be too intimidating. He then looked at some generic tapes but found them inadequate for what he wanted to accomplish. "They didn't reflect the way I practice medicine or say what I wanted to say." So he developed DYALOG, a company which produces customized videos for physicians who want to send clear individualized messages to their patients.

His first tape was a general video that introduced new patients to the staff and operating procedures of his office. He later produced tapes on specialized procedures including arthroscopy, fractures and carpel tunnel syndrome.

In each of the videos Doctor Fitzsimmons provides details of the operations. The overriding message, however, is that each patient is responsible for his own health. Doctor Fitzsimmons states, in what amounts to a public disclaimer, that he is the physician and will do his part, but the patient's health is ultimately the patient's responsibility.

Open dialogue vital

Helping patients accept responsibility for their health care also involves providing them with all the information they require to make informed decisions. Doctor Fitzsimmons invites his patients to ask as many questions as they like and he uses the videos to spell out bluntly the risks of each procedure. He lets his patients know they can suffer such complications as blood clots, cardiac arrest and contract infections in the course of an operation.

Laying out the risks upfront could be seen as offensive but Doctor Fitzsimmons feels that it is important for patients to know exactly what they are in for. "The information is not meant to be frightening, it's meant to be informative," he says. No one really knows how much patients don't understand and Doctor Fitzsimmons has found the tapes useful in triggering specific questions and empowering patients to ask more questions.

By promoting communication it is possible to build a rapport with the patient. Research has shown that if the patient likes his physician he is less likely to sue. Doctor Fitzsimmons sees it more simply. "They won't expect me as a physician to be perfect because they understand my role."

The scripts for each of the videos are reviewed by legal counsel to ensure their accuracy. Doctor Fitzsimmons has never had the tapes tested in court but, he says, it "seems obvious to me that if the basis of suit is something on tape then it is a good defense."

Many fringe benefits

Although Doctor Fitzsimmons receives a special rate reduction from his insurance company for his active efforts to avoid malpractice, there is no tangible way of measuring how successful the tapes have been in deterring malpractice suits. He has found, however, that the concept that he introduced as a risk management tool has some much appreciated side benefits, which more than compensates for the $5,000 - 10,000 cost of the videos.

The videos help with time management, he says. Patients can make appointments more quickly, they are processed more efficiently and it is no longer necessary to spend time outlining basic information about the practice.

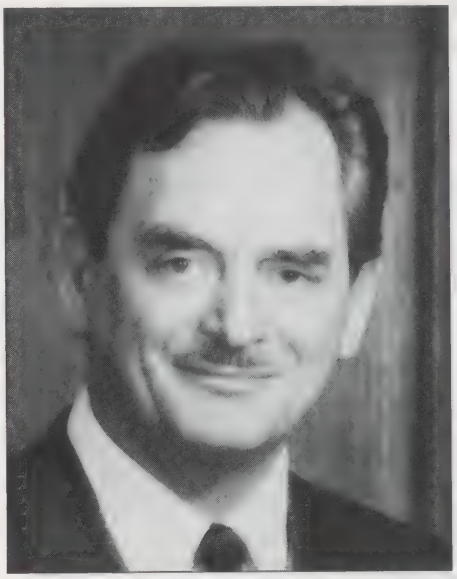
Doctor Fitzsimmons also has noticed the impact of the tapes on how patients perceive him. "It gives you more credibility having the patients see you on TV," he says. "Patients see you much more as an authority."

We can do something about malpractice, insists Doctor Fitzsimmons. "Most of my patients are patient referral, which indicates my patients are pleased with the care they receive," he says. "And I feel happy to give that care knowing my patients are willingly taking responsibility for their own health care."

Helen Fordham is chief of community relations for MSMS.

Cover Story

What better way to show your concern for human life than by planting trees?



Alfred Swanson, MD

Here's the story of one Grand Rapids physician who hopes to plant one million trees by the year 2000.

Nearly one-third of the earth's trees have been destroyed, lakes are atrophying across the country, acid rain is intensifying and the hole in the ozone layer is getting bigger. If this was a human we would have a code blue.

The situation is so critical that it has been estimated that the greenhouse effect could destroy all life on earth within 100 years. Yet, despite the grimness of this projection, Grand Rapids orthopaedic surgeon and environmentalist, Alfred Swanson, MD, remains positive. He believes trees may be the salvation of the planet.

"It is estimated that we need to plant one trillion trees in this earth in the next 20 years if we are to have any chance at combatting the greenhouse effect," says Doctor Swanson, who is director of orthopedic surgery at Blodgett Memorial Hospital. "My goal is to plant one million trees in Kent County by the year 2,000." They will be his contribution to saving the planet. "Ideally I'd like to see a million planted in each of the 83 counties in Michigan, and if all 3,000 counties in the United States did their part there would be three billion planted."

These are rather daunting goals. But Doctor Swanson, who has a history of community activism, has not hesitated.

From the moment he first saw the decimation of the Amazon rain forests on a trip in 1981 he was committed. He remembers being horrified and angry at the total disregard for nature. He realized the seriousness of the situation as he learned that three billion acres of forestland have been destroyed since the second world war. "That's the size of India and China together," he exclaims, "and one third of the trees on the planet!"

"Think globally, act locally"

Anxious to translate his anger to action, Doctor Swanson acted on the environmental axiom, "Think globally, act locally." He established the Alternative Methods for International Stability Organization in Kent County in 1987 and as its chairman he initiated the International Tree Corps.

"I prefer to look at the environment by focusing on trees," says Doctor Swanson. Trees have the ability to process carbon dioxide and other toxins, which are responsible for trapping solar radiation within the atmosphere and causing the greenhouse effect. Scientists believe if enough trees are planted they may help sponge up the pollutants.

A more immediate advantage of tree planting is that it is the easiest thing you can do, yet it is the beginning of awareness, explains Doctor Swanson. "A tree is a symbol of environmental protection and this carries over into concern for everything." Tree planting is one technique of getting the average person motivated to take action, he says. "If we get people angry or concerned enough about the environment they'll act."

The concept of Doctor Swanson's tree planting program is simple. He raises money by asking individuals and businesses for donations which he uses to buy trees. Last

Continued on page 25

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

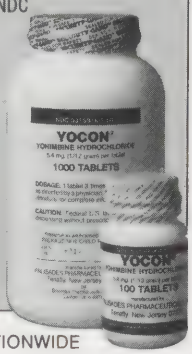
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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year he raised $35,000, but the purchase of the trees cost $70,000. The sizeable shortfall is made up by the revenue from his foundation.

After the trees are purchased they are distributed to volunteers, who are ever diminishing, and children in Kent County, who plant them around the community. Doctor Swanson encourages children to be involved because they are motivated and interested. "The point is to make people feel responsible at a young age for the environment," explains Doctor Swanson. "I hope they will become advocates and teach others, including their parents, the value of what they learn."

In the last five years the tree corp has planted a total of 120,000 trees, a long way from its goal. There are plans, however, to continue planting trees on fallow farmland and along interstate highway medians. Doctor Swanson feels that it is important to succeed locally so he can go on and challenge others nationally to do the same. Yet, he has not confined his activities to Kent County. He continues to raise environmental awareness by giving international lectures, organizing symposiums and supporting environmental legislation. He also has successfully transplanted his tree planting project to Peru and Thailand. Most recently, he attended the Environmental Summit in Rio De Janeiro.

With all this activity it would be easy to label Doctor Swanson a crusader. Yet he scoffs at the idea he is a "tree hugger." His activity is motivated by a sense of citizen concern and responsibility and as a tithe to the global community in which he lives. "I feel responsible for the type of planet my great-great-grandchildren will inherit. We have a responsibility to maintain the environment so people and lesser species can survive."

Instead of being overwhelmed at the thought of dealing with the seriously damaged environment, Doctor Swanson believes in the power of the individual to effect change. He wrote regularly to former President Bush imploring him to take action during his term of office. "In my opinion, the environment is equal or more important than business or government," says Doctor Swanson. "If something is not done then the planet as we know it is going to disappear." Yet Doctor Swanson remains optimistic. "I believe we still have a chance if we act immediately. Together we can prevent global warming." *–HF*

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MSMS priorities for 1993 provide many opportunities for physician involvement

Decide now to become an active participant. Like communication, participation is key to improving your professional image.

MSMS has established several priorities for 1993 which address numerous topics of key concern to physicians. Following is the list of topics with MSMS-designated priorities. Study them carefully and then decide how you can become involved in making these goals a reality.

Patient Advocacy:

Quality of Care

- help develop practice parameters
- expand quality assurance activities
- increase risk management programs
- organize Annual Scientific Meeting offering 50-plus CMEs
- offer Maternal and Perinatal Health Conference-11 CMEs
- conduct Sports Medicine Conference
- expand seminars on state and federal regulations

Health Care Reform

- publicize the benefits of the AMA's "Health Access America"
- hold public forums on health care reform
- work with state government on local reform initiatives
- promote the Physician Sponsor Plan to improve access for Medicaid patients

Public Health

- emphasize disease prevention through liaison with Michigan Department of Public Health
- promote healthy lifestyles for youth including the areas of violence, AIDS and other STDs, substance abuse and mental health
- support tobacco tax increase
- work with MDPH to address high infant mortality rate
- fight for survival of rural practices, hospitals and clinics
- continue to develop Medicare "Senior Courtesy Card Programs"
- work to identify and improve environmental health risks

Domestic Violence

- increase awareness for detection, treatment and prevention
- educate physicians and public
- initiate new laws to control spouse, child and elder abuse
- help hospitals develop victim recognition and treatment protocols
- encourage formation of community coalitions

Physician Assisted Suicide Forums

- continue to lead public debate and discussion
- develop statement for House of Delegates
- monitor developments in new law
- promote use of Durable Power of Attorney for Health Care
- expand seminars on pain management for terminally ill

AIDS Education

- continue to educate physicians, other health care workers and public through speakers' bureau
- monitor AIDS legislation

Medical Liability Reform

- work to improve access and control costs through medical liability reform
- continue to work with 70-member Michigan Medical Liability Reform Coalition
- seek legislation to control non-economic damages, tighten statute of limitations, improve pre-suit notification, improve expert witness qualifications, and establish a sliding scale contingent fee
- continue to work with MSMS Auxiliary in reform efforts

Scope of Practice

- protect patients from health care practitioners who seek expanded scope of practice without appropriate education

Representing Physicians:

In the Legislature

- support medical liability reform
- support legislation to reform Blue Cross/Blue Shield
- support public health initiatives including tobacco tax
- work with state government on health care reform
- support physician licensure and discipline reform
- increase MDPAC participation
- increase grassroots participation

With BCBSM

- work to develop universal claims form
- work for a fairer, faster appeals process
- increase input into new BCBSM products
- continue study of payments in Michigan and other states

In Medical Economics

- continue education on Medicare implementation of RBRVS
- continue efforts to correct Medicare payment inequities
- disseminate data on Michigan physicians collected through the MSMS Survey of Practice Characteristics
- disseminate data on health care cost and delivery trends through the MSMS "MD Data" newsletter
- continue to improve Workers' Compensation rules
- fight to keep fee schedule out of no-fault auto insurance reform

In Practice Management

- offer 150-plus practice management conferences and seminars
- educate members on use of electronic claims processing
- develop and promote elements of the "ideal" physician office
- offer office consultations on billing and coding problems

With Ombudsmen

- Reimbursement Ombudsman to help individual physicians with third-party payment problems
- Regulatory Ombudsman to assist physicians and office staff in state and federal regulation compliance
- Michigan Peer Review Organization Ombudsman to assist with peer review complaints
- National Practitioner Data Bank Ombudsman to assist with reporting and inquiry functions
- assist with issues affecting medical staffs, hospital boards and administrations

Through Physician Service Group, Inc.

- continue to offer a comprehensive selection of member benefits and services including health and dental plans, medical billing, debt collection and equipment leasing

In Legal Matters

- continue to support the position of physicians in legal matters, particularly through the use of amicus curiae briefs
- offer medical staff by-law review service
- offer contract review services
- offer assistance to physicians negotiating with hospitals and other entities

In Physician-Hospital Organizations (PHOs)

- help develop physician organizations
- develop and promote local physician-hospital organizations

In Physician Well-Being

- develop programs to teach self-care skills for physicians and their families to cope with stresses unique to the medical profession
- promote health of physicians and their families to help avoid impairment so they can continue to care for their patients

In Identity, Media and Public Relations

- provide media with fast, accurate information and opinions from MSMS on breaking news stories
- continue to develop Physician Communication Network (PCN) through media training workshops
- foster dialogue with members and the public through findings of "Medicine in the Year 2002" study

In Communication with Colleagues

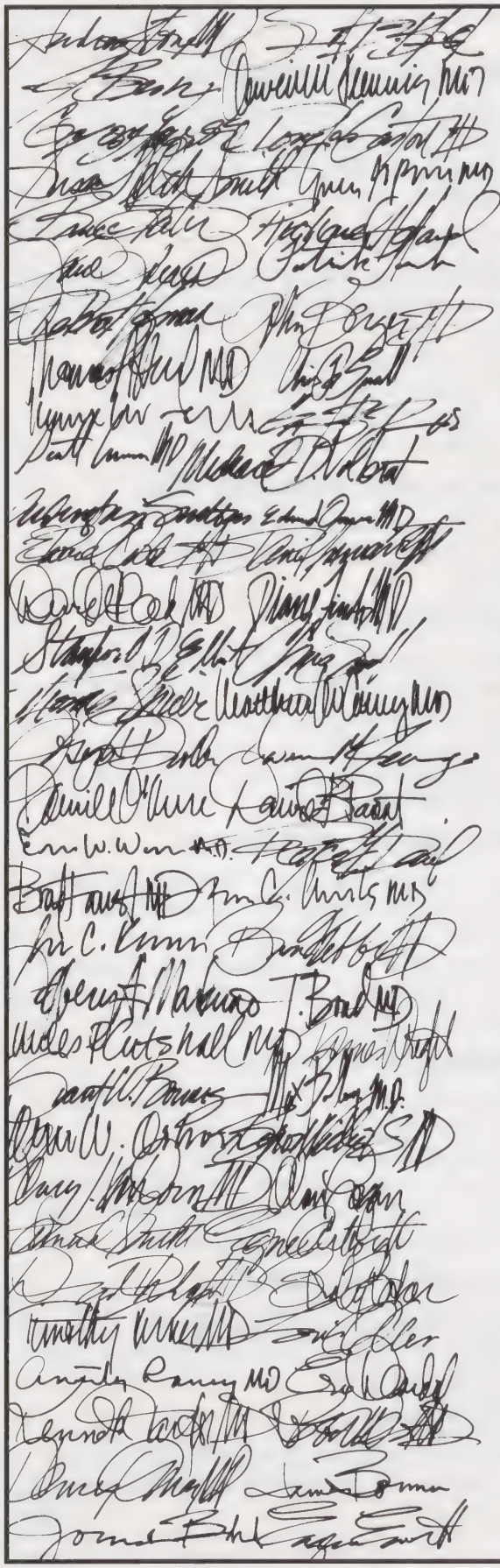
- promote educational and advocacy programs through *Michigan Medicine* and *Medigram*
- offer opinion forum through *Michigan Medicine*
- continue to improve communications with county and specialty societies, hospital staffs, IMG Section, young physicians, residents and medical students

In the Physician Recovery Network

- continue to provide assistance to physicians with chemical dependency, mental illness, stress disorders or physical challenges

In Non-Dues Income

- continue to improve member services without dues increase through development of non-dues income sources



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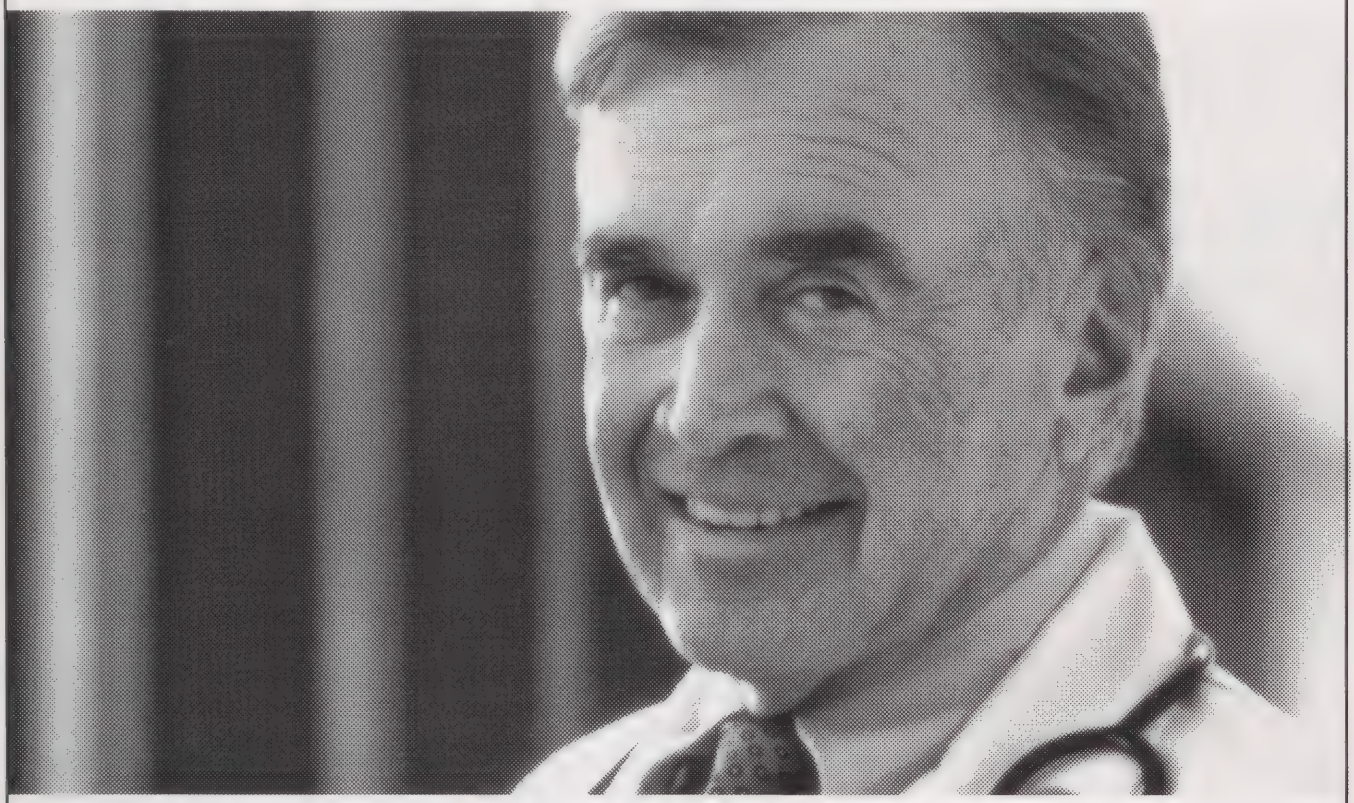
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Legislative ban on assisted suicide:

Impact on Michigan's medical practice

By Howard Brody, MD

> "The main message for Michigan physicians is that outside of a narrowly circumscribed set of actions, the law should have no impact on current medical practice."

On December 3, the Michigan Legislature passed a bill creating a 15-month study commission to report on assisted suicide. While the commission completes its deliberations, assisting a suicide will be classed as a felony, punishable by up to four years in prison. The law appears destined to be signed by the Governor and to take effect in April, 1993. A court challenge to the constitutionality of the law is almost certain, but the likely success of that challenge may be doubted.

I will discuss here some of the events surrounding the passage of this legislation, the details of the legislation, and finally its likely impact on medical practice. Specifically, *the law will not prevent physicians from honoring patients' and families' requests to discontinue treatment, or from administering adequate pain control.*

The House subcommittee on death and dying, chaired by Rep. Lynn Jondahl (D-East Lansing), recommended the formation of a study commission, and the careful legal regulation of assisted suicide while the commission deliberated for two years. The fact that the full House soundly rejected this recommendation, and instead voted for a complete ban, is due largely to an ironic alliance: Right to Life of Michigan and Doctor Jack Kevorkian.

Right to Life remains virtually the only organization favoring a ban on assisted suicide. Its power in the Michigan legislature is shown by the strong vote for banning assisted suicide – despite repeated public opinion polls showing between 55 and 65 percent in favor of the right to die with a physician's assistance.

But the overwhelming vote in favor of the ban may well have been the result of Doctor Kevorkian's (eighth) suicide assistance. (Editor's note: As of press time, Doctor Kervorkian had just participated in his ninth assisted suicide.) The day before the House was set to vote, Doctor Kevorkian aided the death of a cancer patient from Pennsylvania, in the face of some controversy (a friend told the media that the patient was depressed and had not made a rational choice to die). The fact that Doctor Kevorkian was again running "out of control," coupled with the arrival of a patient from out of state to seek his services (raising again the specter of Michigan as the "Suicide mecca of the US"), probably swelled the vote considerably. Virtually all the arguments on the House floor had to do with the perceived need to "stop Kevorkian," rather than a dispassionate deliberation of physician-assisted suicide generally.

Another factor that may have played some role in the vote was the defeat in California one month earlier of Proposition 161, which would have legalized "aid in dying" (both mercy killing and assisted suicide). As in Washington state in 1991, opinion polls had showed the proposition leading comfortably only a week prior to election. One could draw the conclusion from the Washington and California ballots that voters may say to pollsters that they favor a right to die with assistance, but when it comes to actually pulling the lever in the voting booth, a revulsion sets in. Michigan legislators may have concluded from this that majorities in opinion polls do not truly reflect public sentiment.

A look at the law

The law that was passed describes in some detail the creation and mission of the study commission; the ban on assisted suicide is a half-page section added at the end.

The commission will consist of 18 members drawn from a wide cross-section of public and professional organizations (MSMS being one). The original two-year study period was shortened by an amendment to 15 months. At least three pages of the law is devoted to a detailed list of findings the commission is supposed to issue – for instance, the epidemiology of suicide both in Michigan and around the US, and the likely impact of various laws on the suicide rate. (In my opinion, a detailed study of everything on the list would probably take a commission at least five years.) The commission in the end is supposed to advise the legislature on

appropriate public policy regarding suicide and assisted suicide.

The ban on assisted suicide is temporary and expires six months after the commission has issued its findings. Assisting a suicide is defined as either providing a physical means, or participating in a physical act, by which another person attempts or commits suicide. The law is not applicable to a licensed health care professional who withholds or withdraws medical treatment in accord with other laws. Also, a licensed health professional who administers or prescribes medication or procedures for pain control is not guilty of assisting a suicide, even if the treatment hastens death, "unless the medications or procedures are knowingly and intentionally administered, prescribed, or dispensed to cause death."

Its impact on medical practice

The impact can be viewed under two headings: physicians who might wish to assist a patient's suicide; and physicians providing uncontroversial and currently accepted forms of compassionate care for incurably or terminally ill patients.

Assisting a suicide. At least a minority of concerned and thoughtful Michigan physicians view assisting a suicide as an appropriate service to a suffering patient who voluntarily requests it. Such physicians would presumably agree with the clinical criteria for physician-assisted suicide proposed by Quill, Cassel and Meier in the Nov. 5, 1992 *New England Journal of Medicine.* These physicians (many of whom have, without fanfare, provided such assistance to carefully selected patients in the past) will of course be disappointed that the new law proscribes this behavior. Many will be dissuaded from assisting patients in this manner; others will continue to assist, but will take careful precautions to avoid detection. The fact that patients and their families anxiously seek this assistance makes it unlikely that those who know about these cases will report them to the authorities. In my opinion, the available (admittedly sketchy and fragmented) data on the incidence of assisted suicide and mercy killing in the US make it highly unlikely that this new law will eliminate the practice in Michigan, even if it succeeds in its announced purpose of dissuading or incarcerating Jack Kevorkian.

Compassionate terminal care. As MSMS legal counsel Richard D. Weber makes clear (see sidebar on page 34), while the language of the law could have been improved upon, it is nevertheless sufficient to reassure physicians that previously endorsed practices (other than directly administering or prescribing lethal agents with the intent of causing the patient's death) remain unaffected by the new law. Specifically, no Michigan physician should feel reluctant to withdraw or withhold life-prolonging medical treatment at the request of the competent patient or of the concerned family. And no Michigan physician should feel reluctant to provide pain or symptom-relief medication, even narcotics in very high doses, so long as the intent is to make the patient comfortable. (We can make clear our intent by noting in the medical record the symptom for which the medication is administered, and that we will not increase the dose further once comfort has been achieved.)

A possible area of ambiguity disappears once we recall that "the law" consists of more than statutes enacted by the legislature. Looking only at statutory law, the cautious physician (or her legal advisor) might conclude that there is only one circumstance in which she can withhold or withdraw life-prolonging medical treatment: when a patient advocate, with durable power of attorney for health care, makes this decision on behalf of an incompetent patient. That might ap-

Continued on following page

Assisted suicide legislation will provide more protection for physicians, says Oakland County prosecutor

By Helen Fordham

"There is a clear distinction between a patient dying as a result of pain management and a patient being assisted to suicide."

One concern physicians may have about the physician-assisted suicide legislation, which passed in December, 1992, is how it will impact efforts at pain management.

According to Oakland County Prosecutor, Richard Thompson, physicians needn't worry. The legislation will not interfere with physicians' efforts to practice pain management and symptom control, he says.

"Physicians can give as much medication as they see fit to alleviate pain, even if the consequences of that medication contributes to the death of the patient," explains Thompson.

Thompson maintains the new legislation will provide more protection for the medical profession by helping to clarify this gray area of the law.

"There is a bright line between a medical procedure with foreseeable consequences of death and a procedure that will cause the patient's death," claims Thompson.

The physician-assisted suicide legislation was passed in an effort to stop Kevorkian and physicians like him from assisting patients to suicide, according to Thompson. He says that it is not an effort to regulate physicians. Before Kevorkian, the legal system was not concerned with what physicians were doing to alleviate pain, says Thompson, and they won't be now.

Defense may become necessary

Despite assurances that this legislation will do nothing more than stop Kevorkian there is no guarantee that physicians won't, at some stage, have to defend their actions in a court of law. "There is always a chance," says Thompson, "although it's highly improbable."

Under the language of the bill it is the *intent* of the physician that will determine whether the death was assisted suicide or not. And intent is difficult to prove. "I don't think physicians should be concerned," says Thompson. "This act will be compassionately applied by prosecutors."

Helen Fordham is chief of community relations for MSMS.

Continued from page 33

pear to be the case, because the durable power of attorney for health care law (passed in 1990) is the only Michigan statute that *specifically* addresses the right to forgo life-prolonging medical treatment.

But this approach ignores the fact that common law and case law recognize many other modes of forgoing treatment, even in the absence of a specific statute: competent patients can refuse treatment for themselves; incompetent patients may refuse treatment via a written document or "living will"; and the families of incompetent patients may refuse treatment on the patient's behalf, by showing that refusal is either in the patient's best interests or consistent with the patient's previously verbalized wishes. (For an excellent discussion of how all these practices are grounded in common law or case law, see Alan Meisel, "Legal Myths About Terminating Life Support," *Archives of Internal Medicine* 151:1497-1502, 1991.)

It is therefore safe to conclude that when a patient, patient advocate, or family member refuses medical treatment in good faith *by any one of these various mechanisms,* the physician who honors that request acts within the existing law, and is therefore untouched by the new law which bans assisted suicide.

The future of compassionate care

Currently, MSMS is beginning a series of educational programs, designed to enhance physicians' skills in three areas deemed critical to compassionate care for the irreversibly or terminally ill:

- Knowing how to administer the best modern pain and symptom control techniques, or to whom to refer for such assistance;
- Reassuring all patients that their competent refusals of any medical therapy will be honored;
- Counselling patients on how to complete durable power of attorney for health care, so that their wishes can be honored if they later become incompetent, and assuring that these wishes are carefully documented and later followed.

MSMS will not be content with educating physicians on these matters. We also intend to educate the general public on what they can legitimately expect from well-trained physicians. The reaction to Doctor Kevorkian's campaign (and testimony gathered by Rep. Jondahl's subcommittee) has convinced the MSMS Committee on Bioethics that the public has to a large extent lost faith in us, and fears that we will ignore their pain and suffering and keep them alive with medical technology in opposition to their stated wishes. We believe that only an aggressive campaign, aimed at bringing *all* medical practice in Michigan up to the high standards now set by some of our physicians, hospitals, and hospice programs will reassure the public that we are on their side, and that they need not seek assisted suicide as the *only* means to a pain-free and dignified death with some measure of personal control.

To those physicians who believe that serving their patients well entails keeping the assisted-suicide option open, the new law will be a setback. MSMS has not yet adopted a definitive statement on the ethics of physician-assisted suicide; and these physicians may work within our organization to try to gain an endorsement for their views, just as other physicians will be working just as hard to assure that MSMS never endorses physician-assisted suicide under any circumstances.

The Committee on Bioethics believes that this debate over the ethics of assisted suicide could go on for years; and meanwhile, many of our patients are facing suffering, pain, and terminal prognoses. We can do a great deal for those patients to improve the quality of their lives and to offer them appropriate control over their medical care. The new law on assisted suicide need not interfere with these efforts. We owe it to our patients and ourselves to redouble our efforts toward more compassionate and respectful care for those whom we cannot cure.

Doctor Brody is chair, MSMS Committee on Bioethics, and professor of Family Practice and Ethics and Humanities in the Life Sciences at Michigan State University.

MSMS legal counsel issues opinion on physician-assisted suicide

MSMS legal counsel, Richard D. Weber, of Kerr, Russell & Weber, Detroit, recently issued the following opinion on physician-assisted suicide:

"The new law provides that the felony section (of the bill) shall not be applicable to nor affect any other laws applicable to withholding and withdrawing medical treatment. This is ambiguous in the sense that the only clear other law is the durable power of attorney legislation. Nevertheless, I do not believe physicians should feel compelled to change accepted practice in this area or in the administration of pain medication as a result of this legislation. In order for the legislation to apply, the physicians must have requisite knowledge of the patient's suicidal intentions and the specific intent to assist in the suicide by providing the physical means or participating in the physical act."

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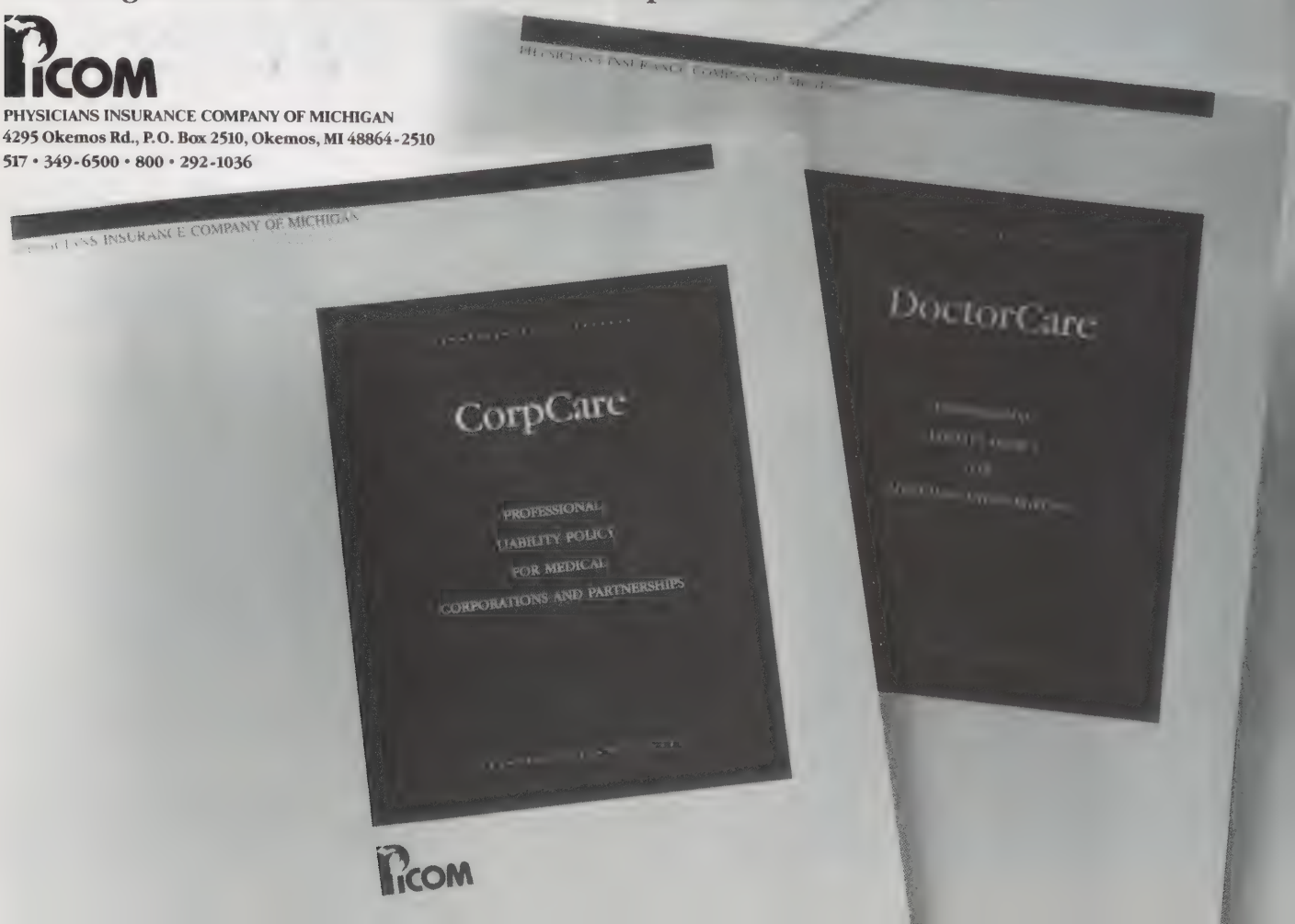
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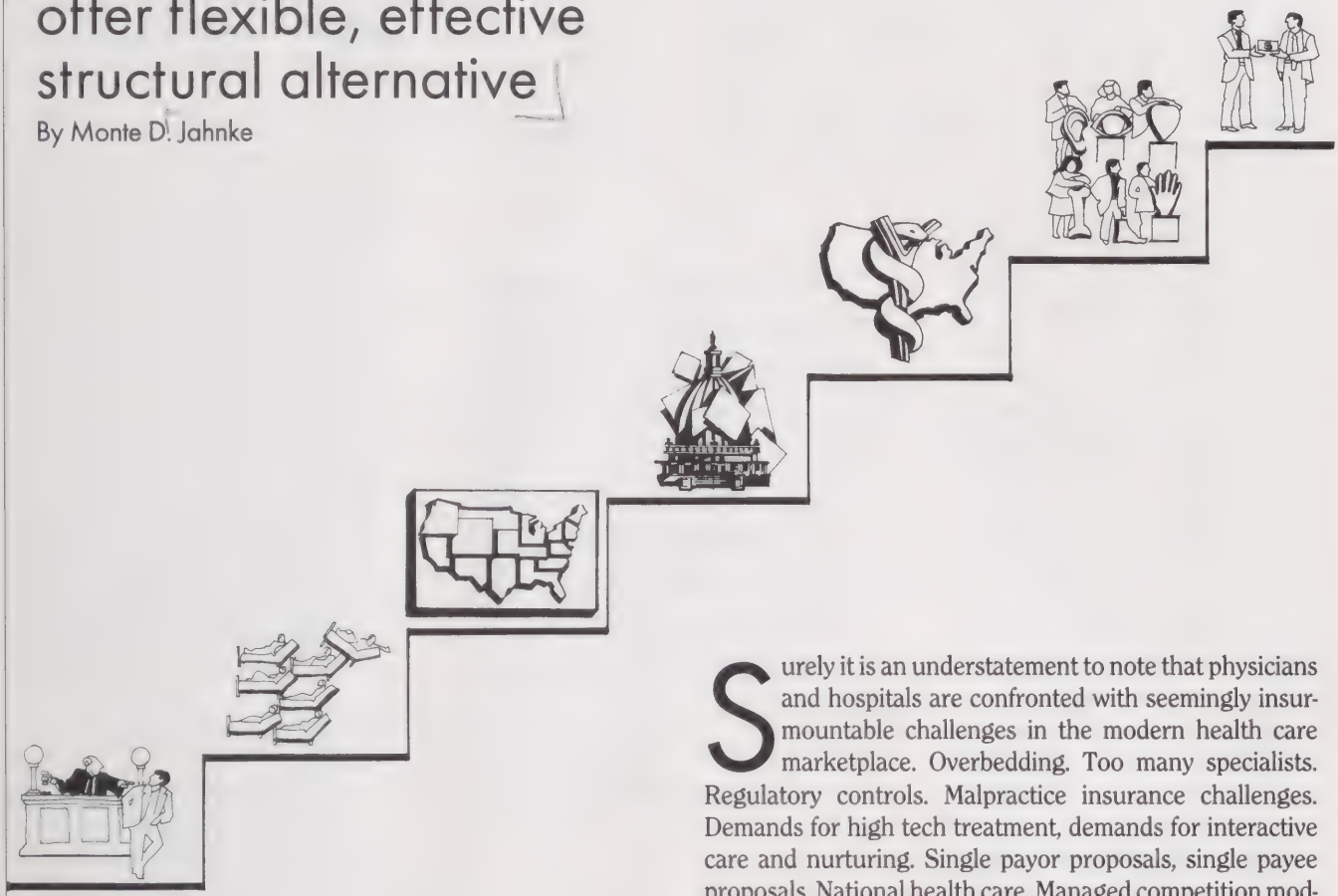
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NOW IT'S PHOs

New Physician Hospital Organizations offer flexible, effective structural alternative

By Monte D. Jahnke



Surely it is an understatement to note that physicians and hospitals are confronted with seemingly insurmountable challenges in the modern health care marketplace. Overbedding. Too many specialists. Regulatory controls. Malpractice insurance challenges. Demands for high tech treatment, demands for interactive care and nurturing. Single payor proposals, single payee proposals. National health care. Managed competition models. Regional health systems. The list goes on.

Success, survival and continued delivery of quality cost effective care will be achieved by those physicians and hospitals who begin to work together now toward positive change. The multiplicity of issues in the health care marketplace requires informed and creative responses. Arrangements need to be structured which can react quickly and participate in the changing marketplace priorities of modern health care. PHOs (physician/hospital organizations) are already providing flexible and futuristic responses for hospitals and physicians in Michigan.

Today's PHOs are a reconstituted perception of hospital/physician joint venturing which can trace its roots to earlier development of so-called Mesh organizations during the 1980's. Mesh and pre-Mesh entity formation in Michigan by-and-large yielded spotty success. Some never became operational; others have carved a place for themselves and seem to be well positioned for positive development, pro-

Continued on following page

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vided that leadership, funding and a patient base are available. Many and perhaps all should revisit their plans and structures in light of the current market environment.

The risk shift phenomenon

In recent years, attorneys in our firm's health care group have been asked by hospitals, physicians and health care consultants to assist in the formation of PHP's and in the restructuring of Mesh entities. These efforts can parallel other initiatives by a hospital and its affiliated staff such as group practice formation. The trend toward financial risk shifting from payors to providers has been behind many of these efforts and has caused hospitals and physicians to band together. The risk shift phenomenon requires providers to put in place systems which will help syndicate or better organize the distribution of such risks while preserving balance between physician control of clinical concerns and hospital influence related to organization and management. The modern universal pressure to manage risk will no doubt allow PHOs to succeed where many Mesh organizations failed or were not completed.

Increased regulatory pressure and the proliferation of managed care and integrated health plans also makes it prudent for a hospital and interested medical staff associates to present themselves to the marketplace cooperatively in some sort of unified structure. These modern health systems see no benefit to working separately with hospitals and physicians. New PHO structures may exist alongside the traditional hospital/medical staff configuration dependent on separate private practices. However configured and whatever their initial mission, they do provide a workable alternative with promise for the future.

> "The multiplicity of issues in the health care marketplace requires informed and creative responses. Arrangements need to be structured which can react quickly and participate in the changing marketplace priorities of modern health care. PHOs (physician/hospital organizations) are already providing flexible and futuristic responses for hospitals and physicians in Michigan."

Simplicity is dependent upon cooperation

Various forms of ownership and control are possible when creating a PHO. The simplest form appropriate to a particular hospital/physician setting is unquestionably the best. Achieving simplicity, however, is most often a function of how cooperative the hospital/physician relationship is in the first place. Some PHOs include joint ownership between a hospital and an interested group of physicians. In other settings, it is first necessary or appropriate for the physicians to form a component or sub-organization which itself becomes a co-owner of the PHO with the hospital. This double-tiered organizational scheme is most useful where the physician group may be disparate or lacks any sort of working or cooperative history among the physicians themselves or with the hospital. For example, in a setting in which there are several small practices affiliated with the hospital and no discernible medical leadership tradition, it may be prudent to form a physician-based organization first as the common vehicle to pursue the cooperative effort with a hospital.

Just because forming a physician sub-component may be necessary during the early stages does not mean that it needs to be perpetuated. Some comparable physician groups formed by our office in the mid-1980s during the initial days of integrated health plan networking are now being dissolved or have become dormant. The rapid pace of change during the past few years also has caused stronger allegiances and bonding between certain hospitals and their medical staffs or components of their medical staffs. In such situations, formation of a PHO can be expedited and its legal structure and ownership can be simplified.

Certain traits, conditions critical

No matter what the form, certain PHO characteristics and prerequisites are critical. First, there must be a more or less equal representation of the hospital and medical components on the governing body of the PHO. Whether the organization will be for profit or nonprofit must be determined early. That decision is often driven by the particular type of hospital and market to be served. The PHO organization itself must be committed to regular and well planned meetings by its board and key standing committees on quality assurance, finance, and provider relations/marketing. The organization must actively pursue a business plan. Adequate early and committed capitalization is essential. Hospital grants or loans, physician contributions, or perhaps even commercial start-up loans should not be ruled out. Fundamental and long-range commitment to survival of the organization is critical, and substantial commitment should be made to on-site professional management and staffing support.

Forming a PHO vehicle to project a unified presentation of hospital and physician services to emerging health care markets may turn out to be the tip of a developmental iceberg. PHOs, if properly designed and managed, can do

several things. This hospital/physician forum can deal more directly and efficiently with questions of resource allocation, problem solving associated with patient services, peer review, utilization management, and tailor-made credentialing associated with the increasingly low profit margin product and services demands of the marketplace. There also exists increasing dialogue in current health care circles and literature about the concept of seamless care, regional or community health systems and even product or brand identity in health care purchasing. A PHO can provide an implementation vehicle necessary to address these trends.

Common goals easier to attain

More specifically, a PHO yields increased ability to accomplish common goals for physicians and a hospital bonded through a PHO. These might include development of outpatient surgery centers, wholesale services and supply purchases, development of niche services needed in a given area or by particular employer purchasers, equipment leasing, group billing services, and durable medical equipment programs. Specialized market needs in the delivery of elder care, for example, will require an interactive multidisciplinary approach as our society continues to age and Medicare cost containment pressures multiply.

PHOs, like any new endeavor, are not problem-free. Several important business and legal issues need to be examined while formative tensions inherent in any cooperative effort between hospitals and physicians are being worked out. Legal regulatory policy in the health care area is often conflicting. Balancing and compromising decisions need to be made before and after a PHO is begun in order to address legal and competitive considerations. Designing in flexibility for the future and developing an attitude where change is seen as a challenge and not a deterrent will be vital to any successful PHO effort.

Conclusion

The multiple challenges facing hospitals and physicians in today's health care marketplace have demanded a flexible and effective structural alternative now known as PHOs. In fact, the development of those trends and tensions has almost mirrored and no doubt has driven the evolutionary process of hospital/physician joint venturing. PHOs present multiple opportunities, most of them positive. They present several challenges and are not trouble free. Perhaps best, they bring institutional and professional concerns into a common forum which can emphasize the strengths of each and maximize benefits to all.

Monte Jahnke is a partner in Kerr, Russell and Weber. The firm is legal counsel to MSMS and MPMLC.

MSMS ESTABLISHES COMMITTEE ON PHOs

MSMS now has a committee on Physician-Hospital Organizations. Following is the list of physicians and MSMS staff currently serving on the committee:

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Fred E. Patterson, MD, Co-chairman
Busharat Ahmad, MD
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Gary D. Maynard, MD
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OLIVER DANIEL WOODHOUSE GRIN, MD

How his internal struggle led him to external success

By David K. Fox





Above right: Doctor Grin, at the helm of Collaboration, *sails with his crew during the Audi Key West Race Week. Above: Doctor Grin (left) is all smiles standing next to his biological father, James Woodhouse.*

This article suggested by Kent County Medical Society



"I was always trying to prove myself. It's all tied into the boat. And the real story of the boat is finding my father."

Alex Haley searched for his "Roots" and found them deep in West Africa.

Gail Sheehy presented "Passages" and helped lead many people through troubling life-cycles.

And Oliver D.W. Grin, MD, sailed "Collaboration" through difficult passages that led to his roots, to the father he never knew existed.

"Collaboration" is Doctor Grin's custom-designed 46-foot Nelson/Marek racing yacht. Ambition and "Collaboration," with a generous dose of fate and circumstance, led the Grand Rapids neurosurgeon on an interwoven 30-year journey by sea to a fulfilling face-to-face confrontation with his biological father in a Ft. Lauderdale, Florida, coffee shop.

Doctor Grin's odyssey began in 1962 on the rolling decks of an Inland Steel iron ore freighter sailing the Great Lakes between East Chicago, Indiana, and Duluth, Minnesota. In the Manitou Passage in northern Lake Michigan, the big ship slowed to yield right-of-way to a fleet of brilliant white sailboats on their annual scramble for the friendliest winds blowing from Chicago to Mackinac Island. Two years through his undergraduate studies and earning money for an ambitious goal of completing medical school, the 20-year-old deckhand gazed at the trim, elegant boats and vowed one day to trade his grimy, iron ore dust-encrusted boots for a pair of smooth-soled Topsiders. He planned to stand one day at the helm of a slick, sleek craft and win the Chicago-to-Mackinac race.

The rest of Doctor Grin's family never understood his ambitions. The Grin family came from a traditional, blue-collar background. His drive to achieve lofty goals, including academic pursuits and a career in medicine, did not fit the pattern. During his youth the family moved frequently to various Great Lakes ports as the man he presumed was his father worked the freighters.

"We had a dysfunctional family," Doctor Grin says today. "Personally, I never felt like I fit in. I always felt like the odd man out. Even my appearance was so different from my siblings. People have joked about it."

Doctor Grin endured decades of internal struggle, introspection and self-analysis. He suffered from low self-esteem and the deep rejection and pain syndrome common in abused children.

"I never felt confident about who I was or what I was doing," Doctor Grin said. "My personality was stifled."

"It was this internal struggle that fueled my desire for external success," Doctor Grin said.

Sailing took a back seat to studies for another decade. Two more years at Michigan State University preceded four years of medical school at the University of Michigan. One year of internship and one year of surgical residency at Blodgett Memorial Medical Center in Grand Rapids preceded four years of residency in neurological surgery at the University of Iowa Hospital and Clinics. In 1974, Doctor Grin came back to Michigan and hung his shingle as a private practitioner in neurological surgery in Grand Rapids.

The lure of the sea brought Doctor Grin back to friends' sailboats on tiny Reeds Lake, a small, shallow body of water in East Grand Rapids. It was enough to cause a recurrence of sailing fever and the inevitable need for a boat of his own, then a little bit bigger boat and then a bigger, faster boat. While strolling the marina on Mackinac Island on a summer's day in 1986 as boat after boat motored in at the conclusion of the Chicago-to-Mackinac race, Doctor Grin revealed to his eldest son, Martin, the vow he had taken on the deck of the freighter 24 years previously. That day, Martin forced another vow from this father, to make his dream a reality the following summer, the silver anniversary of the original vow.

Doctor Grin and Martin collaborated to find the right boat, to develop the right crew and to enter the 1987

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Chicago-to-Mackinac Race. Their collaboration brought them a first place finish in their class aboard "Top Gun," a Frers 33-footer. They placed third out of 300 boats overall.

"Collaboration" extends beyond his personal life

In his new competitive hobby, Doctor Grin continued to skipper "Top Gun" through a series of victories. At the same time professionally, he and neurosurgical clinical specialist Dorothy Bouwman, RN, MSN, began developing a philosophy of patient care based on collaboration among the medical staff, hospital, patient and patient's family. The patient is at the center of the health care process.

"The whole health care system is now doctor centered," Doctor Grin said. "We believe it must be patient centered."

Together, Doctor Grin and Bouwman developed the "Ludann Process" of patient education, an open, give-and-take process designed to allow patients to participate actively in their health care decisions.

Included in the Ludann Process are monographs, videos and patient-education conferences between the patient and family members and all medical staff involved in the treatment plan. "The patient makes the ultimate treatment decision based on education and with reasonable goals and expectations," Doctor Grin said. "The patient takes ownership. That makes me a better neurosurgeon. Instead of worrying about getting sued, I'm thinking about the best procedure."

This approach to "collaborative medicine" inspired the name for Doctor Grin's 1989 investment in a bigger, faster sailboat, the 46-foot "Collaboration."

"We sail the same way," Doctor Grin said. "With *'Collaboration.'* It takes the whole team and we have to be super organized and we have to have a plan."

As a debutante, "Collaboration" created a national sensation in the sport of sailing. She won nearly every Lake Michigan regatta, including first in the Port Huron-to-Mackinac Race, and she took the cup in races all over the East Coast and Florida including Key West Race Week, the Newport-to-Bermuda Race and the Miami-to-Montego Bay Race in 1990.

A new beginning

The final pieces of his lifelong puzzle began to fall into place following extensive media coverage of Doctor Grin and "Collaboration" in the Ft. Lauderdale newspapers after winning the Miami-to-Montego Bay Race.

A woman now living in Ft. Lauderdale who knew of his past called Doctor Grin's office in Grand Rapids shortly after the race. She had seen the press coverage of Doctor Grin and she felt it was time he knew the truth about his roots. Doctor Grin was in surgery when she called. She left a message that the man who had raised him was not, in fact, his real father. His biological father, who'd had an extended romance with Doctor Grin's mother in the early 1940s, was 83-year-old James Woodhouse, a retired steel business executive currently living in Ft. Lauderdale.

"I thought it was a joke," Doctor Grin said. But he investigated further and found out otherwise.

"I called him and he denied it," Doctor Grin said.

Doctor Grin flew to Florida to confront the man. He had learned that Woodhouse frequented the American Golf Club coffee shop in Ft. Lauderdale. Doctor Grin found the place, bought a cup of coffee and waited.

Eventually, James Woodhouse walked through the door.

"I went up and introduced myself," Doctor Grin said. "The minute I saw him I knew he must be my father. He finally admitted it."

"Suddenly, the fog in my life lifted," Doctor Grin said. "A lot of things internally finally made sense. I feel as if I've been given a new identity. And I feel that everything I do now, I do much better."

"My personality is just starting to develop," Doctor Grin said. "It's been a boost for me. I have a new life. I have new brothers and sisters. I have new ambitions. I'm reconstructing my whole being."

In honor of his newfound roots, Doctor Grin added Woodhouse as a second middle name.

Doctor Grin's most recent positive result of "Collaboration" was victory in the inaugural Commodores' Cup Regatta in England in August, 1992. While most of the world's eyes turned toward Barcelona and the Olympics, Doctor Grin and his U.S. team of two other boats grabbed the gold in the eight-day, 15-country races near and around the Isle of Wight. The Commodores' Cup now stays in the United States for two years, until the 1994 races.

Three-year-old "Collaboration" now is up for sale. She has done her job. She brought her skipper more joy than ever could be expected.

Flying home from England on the Concorde after the race, Doctor Grin noticed the plane rattled and shook at low speed, but once it hit supersonic, where it is designed to fly, the ride was smooth sailing. As the blue horizon arched below him, he identified with the plane.

"I was always a supersonic kind of guy flying at low speeds," Doctor Grin said. "I've gotten a turbocharge here. At 50, I'm starting over."

"Now that I've resolved my personal life," Doctor Grin said, "I plan to work hard to give back to the health care system, through Ludann and patient education."

At the end of September Doctor Grin was asked to write a chapter on patient education in the second edition of *Neurosurgery.*

"My philosophical side says maybe all of this came to happen for this purpose."

David Fox is chief of media relations for MSMS.

Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation:

Name: Robert L. Alexander, MD, 345 Highland Ct., Plainwell, MI 49080
Action, Date Taken: Affirmed License Revoked; 8-3-90, Fined- $50,000
Reason: Conv-Drug Related

Name: Reynaldo Bellosillo Arceno, MD, 17050 Joy Road, Detroit, MI 48228
Action, Date Taken: 9-18-92, Fined-$1000
Reason: Negligence-Incompetence

Name: Louis W. Berta, DO, 806 Columbus, Bay City, MI 48708
Action, Date Taken: 11-7-92, License Suspended 30 days; Fined-$1000
Reason: Negligence-Incompetence

Name: James D. Bowen, MD, 2234 M-64, Ontonagon, MI 49953
Action, Date Taken: License Revoked, 10-17-92
Reason: Mental-Physical Incompetency

Name: Patrick T. Brady, MD, #1 Sunnyside, Fort Madison, IA 52627
Action, Date Taken: 11-18-92, License Surrendered - three years
Reason: Negligence-Incompetence

Name: John Henry Brook, MD, 15 Joyner Ct., Lawrenceville, NJ 08648
Action, Date Taken: 9-21-92, License Suspended - six months & one day
Reason: Negligence-Incompetence

Name: Zack B. Brown, MD, 5664 Kingsfield Drive, West Bloomfield, MI 48322
Action, Date Taken: 8-21-92, Reinstatement Denied

Name: Richard Paul Capriccioso, MD, 2800 Hunter Heights, West Bloomfield, MI 48324
Action, Date Taken: 10-21-92, License Revoked; Fined-$2,500
Reason: Practice Outside the Scope of License

Name: Frank L. Clark, MD, 872 E. Napier Avenue, Mec-1, Benton Harbor, MI 49022
Action, Date Taken: 9-16-92, License Revoked; Fined-$1000
Reason: Drug Related

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Continued from page 45

Name: Donald B. Garvin, MD, 1420 Center Avenue, Bay City, MI 48708
Action, Date Taken: 7-20-92, License Suspended-6 months & 1 day; Fined-$10,000
Reason: Negligence & Incompetence

Name: Herbert L. Malinoff, MD, 1140 Martin Place, Ann Arbor, MI 48104
Action, Date Taken: 8-21-92, License Reclassified to Unlimited License

Name: John D. McAllister, Jr., MD, 105 Little Deer, Iron River, MI 49935
Action, Date Taken: 9-18-92, Summarily Suspended
Reason: Substance Abuse

Name: Thomas F. Moran, MD, 843 Shafer Street, Flint, Mi 48503
Action, Date Taken: 8-21-92, Reconsideration of Final Order dated 6-1-92, denied

Name: Roger M. Morrell, MD, 27754 Rackham Drive, Lathrup Village, MI 48076
Action, Date Taken: 9-16-92, License Revoked
Reason: Conviction-Drug Related

Name: Atiya Murtuza, MD, 8033 E. Ten Mile, Ste. 104, Center Line, MI 48015
Action, Date Taken: 9-16-92, License Suspended - two years; Fined-$500
Reason: Convic/Fraud

Name: Edward Joseph Slowiak, MD, 38489 Mason Street, Livonia, MI 48154
Action, Date Taken: 9-18-92, Reinstatement Denied

Name: Rene Z. Smith, DO, 3313 North Country Club Rd., New Castle, OK 73065-6341
Action, Date Taken: 10-13-92, Summary Suspension
Reason: Negligence & Incompetence

Name: Joy O. Stephenson-Diehl, MD, 2452 Arrowhead Circle, Bldg. #30, South Bend, IN 46628
Action, Date Taken: 9-21-92, License Suspended - one year
Reason: Negligence

Name: M. David Sutton, MD, 330 N. Saginaw, Sanford, MI 48657
Action, Date Taken: 11-12-92, License Revoked; Fined $5,000
Reason: Convic/Criminal Sexual Conduct

Name: Robert H. Wiley, DO, 461 Tecumseh, P.O. Box 153, Dundee, MI 48131
Action, Date Taken: 6-20-92, Order Granting Reconsideration is Stayed.

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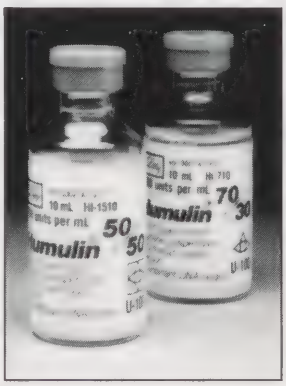
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Kalamazoo, MI 49007

Katherine Spangenberg
1321 Orleans, Apt 1711
Detroit, MI 48207

Continued on following page

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NEW MEMBERS

Continued from page 51

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MEMBERS NYSE/SIPC

OBITUARIES

Charles J. France, MD
Harper Woods

Charles J. France, MD, a retired surgeon, died October 5, 1992. He was 75. A 1942 graduate of the Wayne State University School of Medicine, Doctor France was affiliated with St. John Hospital and taught medicine at WSU. He was a past president of the Wayne County Medical Society and a member of MSMS.

Robert Jaedecke, MD
Green Valley, AZ

Robert Jaedecke, MD, a retired surgeon, died November 6, 1992. He was 76. A 1941 graduate of the University of Michigan Medical School, Doctor Jaedecke was a fellow of the American College of Surgeons. He was a member of the Marquette Alger County Medical Society and MSMS.

James Lauridsen, MD
Port Huron

James Lauridsen, MD, a retired surgeon, died November 6, 1992. He was 74. A graduate of the University of Nebraska Medical College, Doctor Lauridsen was affiliated with Port Huron and Mercy Hospitals. He was a member of the St. Clair County Medical Society and MSMS.

Paul Muska, MD
Brighton

Paul Muska, MD, a retired obstetrician, died September 26, 1992. He was 82. A 1936 graduate of the Wayne State University School of Medicine, Doctor Muska was affiliated with Providence Hospital. He was a member of the Wayne County Medical Society and MSMS.

Samuel J. Nichamen, MD
Huntington Woods

Samuel J. Nichamen, MD, a retired pediatrician, died October 1, 1992. He was 86. A 1930 graduate of the University of Chicago Medical School, Doctor Nichamen was affiliated with Harper, Detroit Children's, and Sinai Hospitals. He was a member of the Oakland County Medical Society and MSMS.

Carol K. Platz, MD
Grosse Pte Woods

Carol K. Platz, MD, a retired obstetrician, died September 29, 1992. She was 77. A 1943 graduate of Loyola University Stritch School of Medicine, Doctor Platz was affiliated with St. John and Bon Secours Hospitals, Detroit. She was a member of the Wayne County Medical Society and MSMS.

Nathaniel J. Walton, MD
Coldwater

Nathaniel J. Walton, MD, a retired physician, has died at the age of 91. A graduate of the University of Iowa Medical School, Doctor Walton was a member of the Branch County Medical Society and MSMS.

Nan Denholm Wolcott, MD
Boca Raton, FL

Nan Denholm Wolcott, MD, a retired obstetrician, died September 30, 1992. She was 81. A 1940 graduate of the University of Illinois, Doctor Wolcott was affiliated with Hurley, St. Joseph, and McLaren Hospitals. She was a member of the Genesee County Medical Society and MSMS.

Sigmund G. Zawacki, MD
Grosse Ile

Sigmund G. Zawacki, MD, a retired surgeon, died September 9, 1992. He was 72. A 1945 graduate of the University of Detroit Medical School, Doctor Zawacki was affiliated with Oakwood, Mt. Carmel, and People's Community Hospitals. He was a member of the Wayne County Medical Society and MSMS.

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RC
John J. Turonie, Administrator
The Raiter Clinic, Ltd.
417 Skyline Boulevard
Cloquet, Minnesota 55720

The Raiter Clinic, Ltd. is an equal opportunity employer

MEETINGS

MSMS Meetings

February

2-6, MSMS/MPMLC Risk Management Winter Conference, "Safeguarding Your Future", Keystone Resort, CO. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

4-5, MSMS Practice Management Seminar, "New Medical Biller Training Series-Commercial Carriers and Managed Care Programs", Pretzel Bell Restaurant, East Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

9, 10, 16, MSMS/BCBSM Medicare Update. February 9, Novi Hilton, Novi MI. February 10, Treasure Island, Saginaw, MI. February 16, Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

16, 17, 18, MSMS Practice Management Seminar, "How to Comply with CLIA Regulations." February 16, Troy Marriott, Troy, MI. February 17, Lansing Center, Lansing, MI. February 18, Treasure Island, Saginaw, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

17, 18, 23, 25, 26, MSMS/MPMLC Risk Management: Closed Claim Reviews (Family Practice). February 17, Sylvan Resort, Gaylord, MI. February 18, Treasure Island, Saginaw, MI. February 23, Novi Hilton, Novi, MI. February 25, WMU Regional Center, Grand Rapids, MI. February 26, MSMS Headquarters, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

18-19, MSMS Practice Management Seminar, "Becoming an Exceptional Biller," Novi Hilton, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

22, 23, 25, MSMS Practice Management Seminar, "Improved Collection Practices in the Health Care Office." February 22, Westin Hotel, Detroit, MI. February 23, Michigan Athletic Club, East Lansing, MI. February 25, Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education (517) 336-5784.

25, MSMS Professional Well-Being Workshop, Holiday Inn University Place, East Lansing, MI. Contact: Sherry Fent, MSMS Office of Physician Education, (517) 336-5784.

March

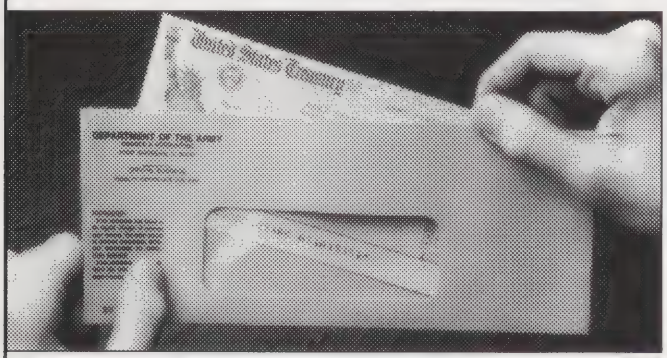
3-5, MSMS/MPMLC Risk Management "Carcinoma of the Breast: A National Liability Epidemic," Shanty Creek, Bellaire, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

5-7, MSMS/MPMLC Risk Management Communications Conference, Shanty Creek, Bellaire, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

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9, 10, 11, 18, 30, MSMS/MPMLC Risk Management: Closed Claim Reviews (Anesthesiology). March 9, Novi Hilton, Novi MI. March 10, Sylvan Resort, Gaylord, MI. March 11, Treasure Island, Saginaw, MI. March 18, MSMS Headquarters, East Lansing, MI. March 30, WMU Regional Center, Grand Rapids, MI. Contact: Julie Smith, MSMS Chief, Risk Management (517) 337-1351.

9, 10, 11, MSMS Practice Management Seminar, "Providing Outstanding Patient Service." March 9, Treasure Island, Saginaw, MI. March 10, Best Western Domino Farms, Ann Arbor, MI. March 11, WMU Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

12, MSMS Practice Management Seminar, "Improving Physician Image: How Do You Communicate Caring?" Radisson on the Lake, Ypsilanti, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

12, MSMS Practice Management Seminar, "Accent Management Workshop," Radisson on the Lake, Ypsilanti, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

12-13, MSMS Joint Section Annual Meeting, Radisson on the Lake, Ypsilanti MI. Contact: Judy Marr, MSMS Manager, Communications and Professional Relations, (517) 337-1351.

16, 17, 18, MSMS Supervisory Skills Series - Part I "Master the Principles of Office Supervision." March 16, Wayne County Medical Society, Detroit, MI. March 17, Holiday Inn, Flint, MI. March 18, Fetzer Center, Kalamazoo, MI. Contact: The Office of Physician Education, (517) 336-5784.

16, 18, 23, MSMS/MPMLC Fundamentals of Risk Management. March 16, WMU Regional Center, Grand Rapids, MI. March 18, Wayne County Medical Society, Detroit, MI. March 23, Holiday Inn south, Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

18-19, MSMS Practice Management Seminar, "Medical Biller Training Series Blue Cross/Blue Shield," Novi Hilton, Novi, MI. Contact: Angela Criswell, MSMS Department of Medical Economics, (517) 336-5723.

24, MSMS Board Meeting, Michigan State Medical Society, East Lansing, MI. Contact: William Madigan, MSMS Executive Director, (517) 336-5734.

24, MSMS/MPMLC Risk Management: Closed Claim Reviews (Obstetrics/Gynecology), Holiday Inn South, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

24-25, MSMS Maternal and Perinatal Health Conference, Holiday Inn South, Lansing, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

25, 30, 31, MSMS Practice Management Seminar, "Coding Clinics for Specialties." March 25, Holiday Inn South, Lansing, MI (OB/GYN). March 30, Hotel Baronette, Novi, MI (Anesthesiology/General Surgery). March 31, Treasure island, Saginaw, MI (Anesthesiology/General Surgery). Contact: MSMS Office of Physician Eduation, (517) 336-5784.

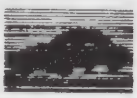
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MEETINGS

Continued from page 55

31, MSMS/MPMLC Risk Management: Closed Claim Reviews (Psychiatry), Sylvan Resort, Gaylord, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

April

1, MSMS/MHA Making the Best of Hospital/Physician Relations, Sheraton Oaks, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

1-2, MSMS Orientation to the Medical Office, WMU Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

6, 7, 8, MSMS Practice Management Seminar, "Electronic Billing: Do You Know All you Need to Know?" April 6, Grand Traverse Resort, Traverse City, MI. April 7, Troy Marriott, Troy, MI. April 8, WMU Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

7, 8, 14, 15, MSMS/MPMLC Risk Management: Closed Claim Reviews (Psychiatry). April 7, Treasure Island, Saginaw, MI. April 8, Novi Hilton, Novi, MI. April 14, WMU Regional Center, Grand Rapids, MI. April 15, MSMS Headquarters, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

8, MSMS CME Accreditation Conference, Michigan Athletic Club, East Lansing, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education,(517) 336-5727.

12-13, MSMS Practice Management Seminar, "Medical Biller Training Series (Medicare)," Novi Hilton, Novi, MI. Contact: Angela Criswell, MSMS Department of Medical Economics, (517) 336-5723.

13, MSMS Program, "Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide," Fetzer Center, Kalamazoo, MI. Contact: Helen Fordham, MSMS Communications, (517) 336-5786.

15, MSMS Opportunities 1993: An Array of Medical Practice Opportunities for Michigan Physicians, Detroit, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

15, MSMS Professional Well-Being Workshop, Holiday Inn, Flint, MI. Contact: Sherry Fent, MSMS Office of Physician Education, (517) 336-5784.

20, 21, 22, MSMS Supervisory Skills Series - Part II (How to Deal With Difficult People and Situations). April 20, Holiday Inn, Flint, MI. April 21, Michigan Athletic Club, East Lansing, MI. April 22, Hotel Baronette, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

20, 21, 22, 27, MSMS/MPMLC Risk Management: Closed Claim Reviews (Pathology). April 20, Sylvan Resort, Gaylord, MI. April 21, Treasure Island, Saginaw, MI. April 22, Novi Hilton, Novi, MI. April 27, MSMS Headquarters, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

27, 28, MSMS Coding Clinics for Specialties. April 27, WMU Regional Center, Grand Rapids (Radiology/Primary Care). April 28, Holiday Inn, Flint, MI (Radiology/Primary Care). Contact: MSMS Office of Physician Education, (517) 336-5784.

29, MSMS Future Vision: Physicians in the Year 2002, Ritz Carlton, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

30, MSMS Board Meeting, Michigan State Medical Society, East Lansing, MI. Contact: William Madigan, MSMS Executive Director, (517) 336-5784.

30 - May 3, MSMS House of Delegates, Ritz Carlton, Dearborn, MI. Contact: Donna Farougi, Coordinator, Special Programs, (517) 336-5735.

May

2, MSMS Board Meeting, Michigan State Medical Society, East Lansing, MI. Contact: William Madigan, MSMS Executive Director, (517) 336-5734.

July

14-18, MSMS Midsummer Board Meeting, Shanty Creek, Bellaire, MI. William Madigan, MSMS Executive Director, (517) 336-5734.

November

9-11, MSMS Annual Scientific Meeting, Westin Hotel, Detroit, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

AMA Meetings

June

10-17, AMA House of Delegates, Chicago, IL. Contact: Judy Marr, MSMS Manager, Department of Communications and Professional Relations, (517) 337-1351.

National Specialty Society Meetings

October

29-31, American Society of Bariatric Physicians, Westin Hotel, Chicago, Ill. Contact: (303) 779-4833.

Other Meetings

March

7-14, Midwest Doctors Medical Seminars, Snowmass Village, Colorado. Contact: Richard Campau, Michigan State Medical Society, (517) 337-1351.

8-13, Thirteenth Annual Mammoth Mountain Emergency Medicine Ski Conference. Contact: Mark Song, MD (714) 552-0831.

10-12, PET and SPECT Brain Imaging in Clinical Practice and Research, Thomas B. Turner Building, Johns Hopkins Medical Institutions, Baltimore, Maryland. Contact: Patty Campbell, Program Coordinator (410) 955-6046 or (410) 955-8582.

18-20, Spring Break for CME PGA National Resort & Spa, Palm Beach Gardens, Florida. Contact: Karen Barnum, Meeting Coordinator, Florida Medical Association,)904) 356-1571.

29-31, Fiberoptics Workshops for the Difficult Airway, Red Lion's La Posada Resort, Scottsdale, Arizona. Contact: Marie McKnight, Registrar, Ann Arbor, MI (313) 936-9800.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

February

2, Considerations of Psychotherapy as Treatment of Choice for Migraines and Back Problems. Location: 3000 Town Center, Southfield, Michigan. **Sponsors:** Bar-Levav Educational Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

17, Joint Injections. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judy Wright, Registration Coordinator, 4909 Hedgewood Drive, Midland, MI 48640, 1-800-462-2492. **Approved for:** 3.5 hours Category I Credit.

18-19, Dermatologic Procedures. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judy Wright, Registration Coordinator, 4909 Hedgewood Drive, Midland, MI 48640, 1-800-462-2492. **Approved for:** 15 hours Category I Credit.

19-20, Advanced Trauma Life Support. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons and University of Michigan Medical School. **Contact:** Steve Cruise, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 17 hours Category I Credit.

20, Advanced Suturing/Coding Procedures. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judy Wright, Registration Coordinator, 4909 Hedgewood Drive, Midland, MI 48640, 1-800-462-2492. **Advanced Suturing Approved for:** 4 hours Category I Credit. **Coding Procedures Approved for:** 4.5 hours Category I Credit.

21-26, Midwinter Cardiovascular Update. Location: Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 20 hours Category I Credit.

March

4-6, Advances in the Management of Infectious Diseases: Winter Update. Location: South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 13 hours Category I Credit.

5-7, Midwest Clinical Conference. Location: Sheraton Chicago Hotel, Chicago, Illinois. **Sponsor:** Chicago Medical Society. **Contact:** Christine Ricker, Assistant Director, Division of Educational Affairs, Chicago Medical Society, 515 N. Dearborn St., Chicago, Il 60610, (312) 670-2550. **Approved for:** 18 hours Category I Credit.

16-20, Family Practice 1993, Seventeenth Annual Spring Review Course. Location: Towlsey Center, University of Michigan, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Michigan Academy of Family Physicians. **Contact:** Robin Rice, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 33 hours Category I Credit.

18-19, Colposcopy for the Primary Care Physician. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsors:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 12 hours Category I Credit.

20-21, Stress EKG. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland MI 48640, 1-800-462-2492. **Approved for:** 11.5 hours Category I Credit.

25-26, Colonoscopy/Common Naorectal Disorders/Hemorrhoids. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland MI 48640, 1-800-462-2492. **Approved for:** 12 hours Category I Credit.

27, Advanced Trauma Life Support, Student Reverification Course. Location: Towsley Center, University of Michigan Medical School, Ann Arbor, Michigan. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons and University of Michigan Medical School. **Contact:** Steve Cruise, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, university of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 3 hours Category I Credit.

27, Fourth Annual Symposium on Medical Complications of Pregnancy: "Medical Emergencies in Pregnancy." Location: William Beaumont Hospital, Royal Oak, Michigan. **Sponsor:** William Beaumont Hospital. **Contact:** Liz Kretschmann, Office of Continuing Medical Education, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073-6769, (313) 551-0429. **Approved for:** 4 hours Catehory I Credit.

27-28, EDG (Gastroscopy). Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National

Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 12 hours Category I Credit.

April

14-16, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400.

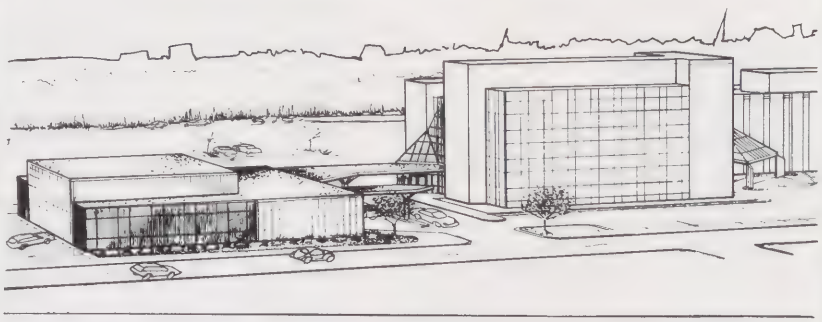
16-17, Sclerotherapy/peripheral Vascular Evaluation. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 11.5 hours of Category I Credit.

23-24, Contraceptive Update/No Scalpel Vasectomy. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, Mi 48640, 1-800-462-2492. **Approved for:** 15 hours Category I Credit.

23-24, Advanced Trauma Life Support, Instructor Course. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons and University of Michigan Medical School. **Contact:** Steve Cruise, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

25, Leep/Letz/Loop. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 5.75 hours Category I Credit.

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Continued on page 63

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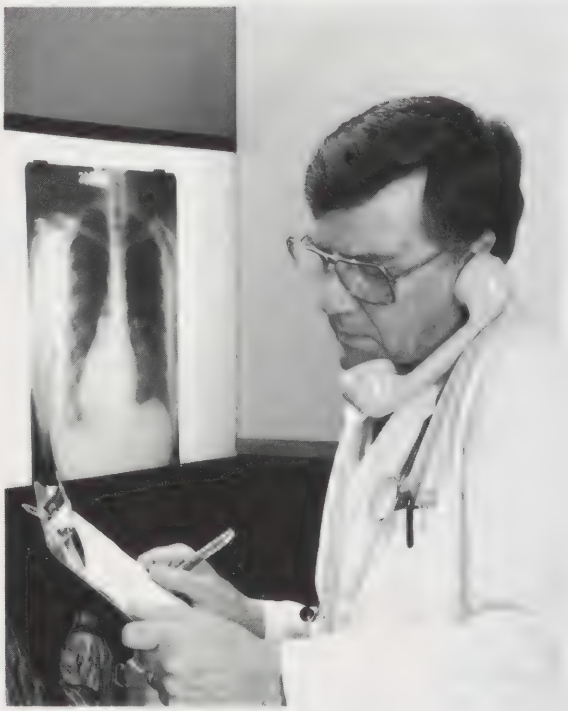
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PRESIDENT'S PAGE

Need for Health Care Reform is *Now*

By Thomas C. Payne, MD



Front page again in the local paper, "U.S. spending on health care heads for $1 trillion this year."

The clamor for health care reform is crescendoing.

The number crunchers say last year's health care costs, at $838.5 billion, were 14 percent of the gross national product. Costs were up 11.5 percent and are estimated to go up another 12.1 percent this year to $939.9 billion.

If averaged out, the 1992 figures represent a health care expenditure of $3,160 for every American.

Of course, few people hit the $3,160 exactly. Many were far, far below that figure and many at that amount times 10 or times 100 or more.

We have the 35 million uninsured and the millions who are under-insured. We have the millions of poor on Medicaid and the millions of seniors on Medicare. And then we have the millions of others with employer-provided health insurance benefits who are facing higher and higher co-pays and deductibles and decreasing benefits levels.

With all of this, the Clinton administration is promising a health care reform proposal within the first 100 days, a proposal to provide coverage to all those currently not covered and to reduce the overall health care bill.

We must take part

It would be easiest to say "Good luck, Bill, call us when you've developed the solution." But I believe, now more than ever on any issue, physicians must become actively involved in shaping a health care system reform proposal.

We must have a two-pronged approach, keeping an eye on developments on the state level and participating actively on the national level.

Even though a health care reform proposal is not likely on the state level, we must remain vigilant. Minnesota, Vermont and Maryland all have made radical changes and Kentucky is in the talking stage. Of course, state-level changes are not necessarily onerous, and in some cases could be important testing grounds for national reforms, but we must keep on eye on the wheat and on the chaff. If any proposals creep into the Michigan legislature, MSMS must and will become a major voice.

National reform holds the only really workable solution for the health care system, but, as we have experienced before, such a course is extremely fraught with peril. All the more reason for us to get involved to address the basic triad of reform including cost, quality and access.

Physicians must be at the center of the debate on national reforms because we must speak for our patients and the profession.

Collaboration key

Physicians must work with the federal government on a collaborative basis rather than an adversarial one. We should seek avenues through which physicians can become more of a partner with government to look at the issues of universal access to health care, cost containment, creation of essential standards and improved self-regulation and anti-trust relief to level the playing field for negotiating Medicare fees.

Physicians also must unite to oppose global budgets for health care. We must oppose expenditure targets or price controls or any ill-advised system of cost containment that may lead to an even greater limiting of access or to out-and-out health care rationing.

And finally, physicians must unite behind the AMA's proposal for reform called Health Access America. AMA continues to refine this plan for universal access with a growing emphasis on managed care and managed competition. The plan builds on the strengths of our current system without destroying it with a socialized system.

More information on Health Access America and other national reform proposals will appear in coming issues of *Michigan Medicine*. Also see the December, 1992, issue of *Michigan Medicine* for a comparison of Health Access America and the preliminary Clinton ideas.

We all must write to our national legislators to back reform aimed at cost control without damaging quality and access. We must continue to be advocates for our patients and our profession, because if we don't, who will?

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/– mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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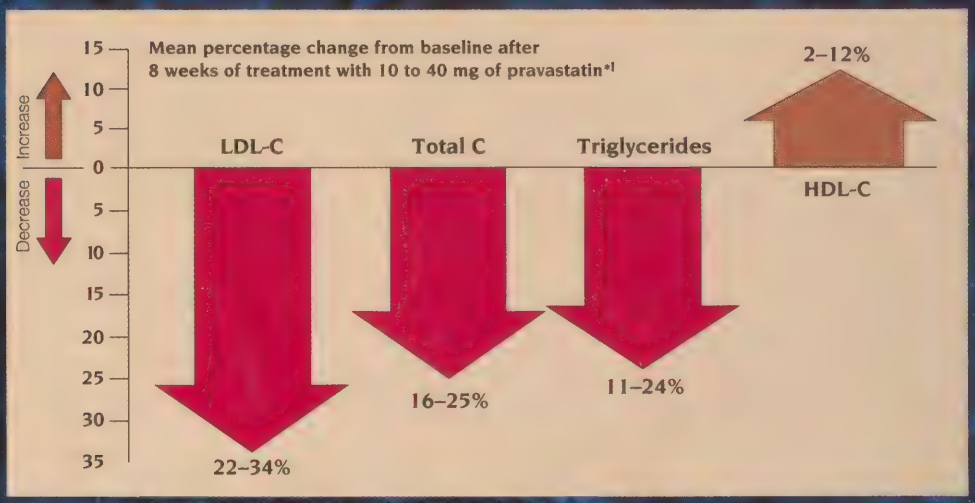
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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol* 1991; 14: 146-151.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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VOL. 92, NO. 3

Award-Winning Journal of the Michigan State Medical Society

Cover Story

Preventive Health Care
The important role of physicians

Medical Inquirer

County Medical Society Spotlight
Kent County

American Russian Medical Exchange

Physician Profile
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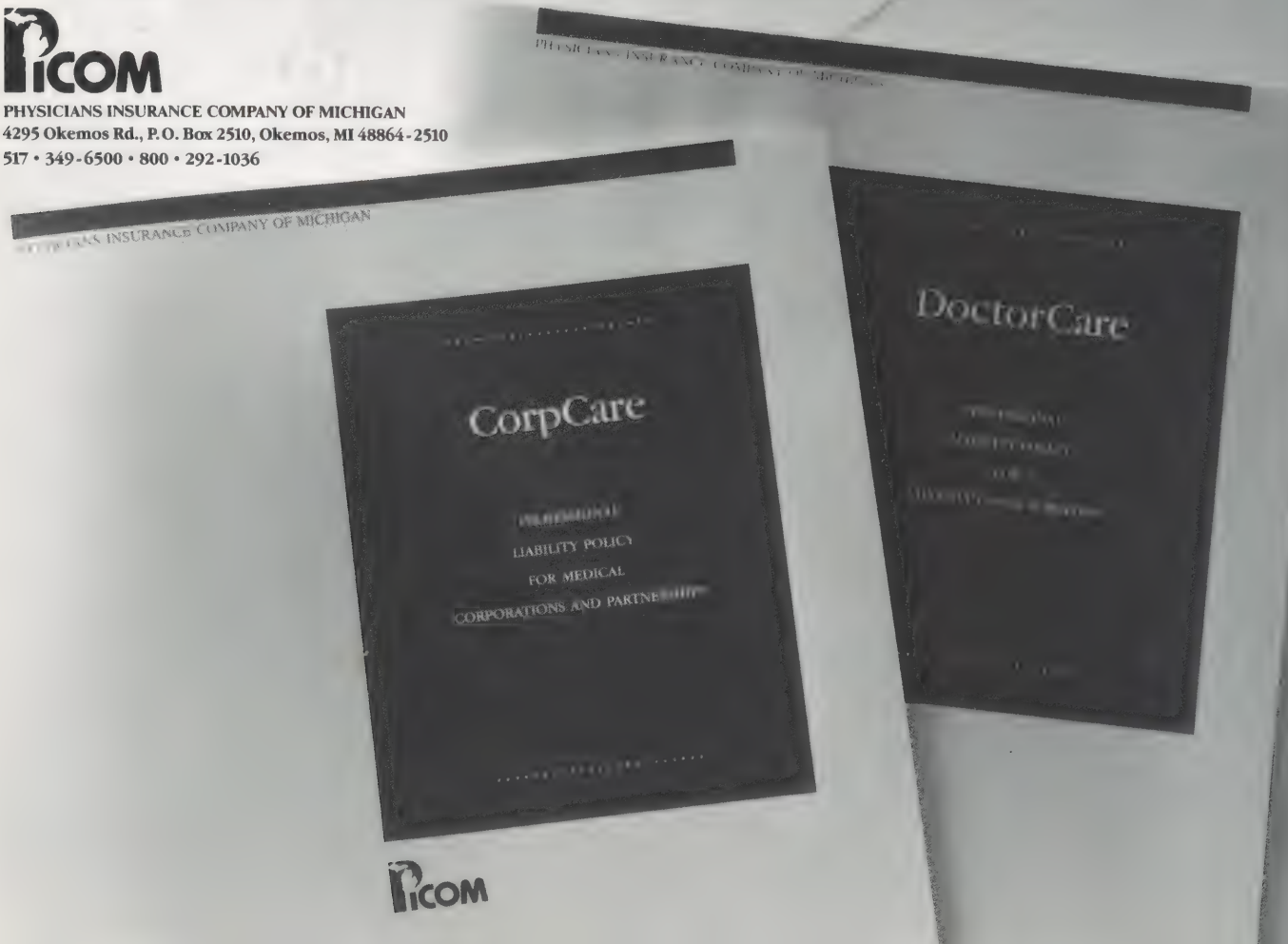
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MICHIGAN MEDICINE

MARCH 1993 VOLUME 92, NO. 3

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

When MSMS conducted a series of focus groups last fall as part of its "Medicine in the Year 2002" project, many of the physician participants said they looked forward to an era in which they would be more involved in preventive health care. By becoming more involved in prevention, they said, physicians could help to control escalating health care costs, create a healthier society and improve their image. This month's cover story explores, in depth, one key public health program in which Michigan physicians can play a fundamental role right now - the Public Health Breast and Cervical Cancer Program. Also included is an article about MSMS President-Elect Gilbert B. Bluhm, MD, and his interest in preventive health care, an area which will serve as a key theme throughout his term as MSMS president, which begins this spring.



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In next month's issue:
Results of MD Data Research Project

Cover illustration: *By Robert L. Brent*

A future of medical excellence starts with a few good ideas



A lot of old fashioned ideas go into 21st Century medicine. Ideas like dedicating resources and energy to things that matter. What matters at Rehabilitation Institute of Michigan is exploring new ways to rebuild lives by designing better ways to diagnose and treat individuals with physical and cognitive disabilities.

We're confronting our future by putting good ideas to work right now. That's why we're developing the first clinical research unit in the nation devoted entirely to rehabilitation research.

We've staffed and equipped our clinical rehabilitation research unit to study the quantification of human functioning. We'll develop and test new equipment, new diagnostic assessment methods, new treatments and use objective outcome measurement.

Trying to improve the future of health care isn't a new idea. But it has given birth to new ways to achieve excellence in physical medicine and rehabilitation.

At Rehabilitation Institute of Michigan, rebuilding lives is our future.

For more information on the Clinical Rehabilitation Research Unit at Rehabilitation Institute of Michigan, call us at (313) 745-9716.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Michigan Medicine (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published once each month, 12 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $100.00 (includes weekly *Medigram* newsletter); single copies, $3.00: Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news and exchanges should be addressed to Betty McNerney, advertising to Pat Horan, and address changes to Kathy Hagen, Michigan State Medical Society, P.O. Box 950, East Lansing, Michigan 48826-0950. Phone 517-337-1351.

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LETTERS

Information sought on human health effects of nonionizing electromagnetic radiation

Our research group is in the process of accumulating data on the human health effects of nonionizing electromagnetic radiation. Specifically, we are interested in nonionizing electromagnetic frequencies in the range between electric power transmission frequencies, and microwave frequencies.

Although there has been a great deal of interest and research on this subject, the information available on the human health effects of this radiation does not permit us to conclude that there are serious health effects.

We believe there is an increase in awareness of both physicians and patients that nonionizing electromagnetic radiation may have some human health effects, with the most prominent being links to neoplastic disease. Of specific interest to us is the potential for collecting cases or clusters of cases recognized by practicing physicians in the United States, which may be related to exposure to nonionizing electromagnetic radiation.

We would be interested in hearing from any physicians or physician groups that may have experience with this problem.

Joseph R. Salvatore, MD
Director
National Registry for the Health Effects of Nonionizing Radiation

Certificate of Need laws increase medical care costs

One of the burdens of being a physician is being blamed for the high and increasing costs of health care. Certificate of Need Laws have been used in many states, including Michigan, to putatively lower these costs. I reviewed the available studies published in the economic literature in the last 15 years on CON to answer doubts that had arisen on the effectiveness of CON.

Brice and Salkever (1977, 1976 and 1979), Joskow (1981), Hellinger (1973), Sloan and Steinwald (1980), Sloan (1981), Eastaugh (1982) studied investments by hospitals using national data. CON limited expansion of bed capacity, and increased investment in plant assets. There were no net cost savings. Hospitals, anticipating enactment of CON laws, started construction projects early, thereby avoiding the initial impact of these laws.

Lee, Birnbaum and Bishop (1983) explored costs of Nursing homes. CON seemed to increase average occupancy and increase average costs.

More recent studies have better data bases and more revealing results. Kelly and Farly (1985) showed that CON was associated with a 3.5 percent increase in hospital costs. Noether (1987, 1988) studied 1977-8 data. CON increased average costs per admission by four percent. Charges increased by more than costs, suggesting that CON increases profit margins of hospitals.

Sherman (1988) showed that if states were to significantly relax their regulatory restraints by doubling the threshold at which hospitals had to submit proposals for review, that total hospital costs would decrease by 1.4 percent. He was unable to project the cost savings from complete elimination of the CON because most states had these laws in the years under review.

Mayo and McFarland (1989, 1991) studied the six HSA (Health Systems Agencies) of Tennessee (1991) and concluded that CON increased health care costs in the four years of the entire study. However, health care costs were significantly lower during the fourth year of CON; this was a promising trend.

Anderson (1991) investigated the effect of duration of CON in the various states on hospital costs. CON increased costs by $270,000 per hospital plus

Continued on following page

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LETTERS

Continued from page 5

about $145 per bed per year for each year that CON had been in effect in a given state. CON increased the variable cost of hospitals by about 5 percent when they had been in effect for 10 years, the average duration in 1984 when the study was done. Costs would increase by about 10 percent if CON were in force for 20 years as they have been in Michigan.

We stress that the "costs" in the above research are measurements of the expenditures reported on the accounting statements of hospitals and other large facilities. Other costs are intimately tied in with CON and include volunteer time by physicians and others to prepare and review proposals, costs supporting governmental agencies, and inconvenience the patients incur in traveling.

Those who are politically advantaged will probably demand that desirable projects be built at hospitals and areas that they find convenient. We wonder whether this accounts for the well documented lower incidence of open heart procedures, later diagnoses of malignancies, etc., of those who live in inner cities. CON can therefore be a subtle form of discrimination and a net cost to society.

Hospitals use CON to deny a competitors favors under CON. The loss of capacity resulting from stringent CON practiced in New York City for nearly 30 years led to unanticipated costs when the health care needs increased because of the AIDS crisis, illicit drug use, and from an aging population. Patients with major illnesses routinely languish for days in emergency rooms. This has not yet occurred in Michigan.

In the last several years, several articles have documented poorer outcomes in facilities that do a lower volume of certain procedures (coronary artery bypass grafts) or who care for fewer cases of some diseases (AIDS). Thus CON could reemerge to become a quality issue. It might be desirable to limit the number of facilities where a service is delivered so that the experience with a procedure or disease is more concentrated, and presumably, of higher quality. I'd guess that it's more effective and cheaper to publish volumes, mortality, and morbidity at various centers. This should serve as a warning to potential patients and referring physicians.

I'm convinced that CON increases medical care costs. If CON increases the $8,076,898,000 expended by general hospitals in Michigan (1989) by four percent, I calculate that CON cost an unjustified $320,000,000 that year.

We physicians should demand that our state legislators repeal these expensive laws.

Erwin J. Haas, MD, FACP
Grand Rapids

Author searching for relatives of Maclean, Campbell families

I am writing to ask your help. I am a medical historian and medical librarian at work on a book concerning Donald Maclean, MD, an eminent surgeon and professor at the University of Michigan Medical School in the 1870s and 1880s. Doctor Maclean's daughter married Alexander McKenzie Campbell (1873-1954), who was a prominent Grand Rapids physician for years. The *Journal of the Michigan State Medical Society* published an issue in Doctor Campbell's memory in 1955 (February, vol. 54, no. 2).

I am trying to locate relatives and/or descendents of the Maclean and Campbell families. I am particularly interested in finding Doctor Campbell's two daughters and any children they may have had.

Catherine Arnott Smith
619 Case Place
Evanston, IL 60202

MSMS ON THE MOVE

A monthly update of key MSMS activities

Government Affairs Day helps doctors talk with lawmakers

Medical liability reform. No-fault auto insurance reform. Assisted suicide. How each of these and other issues are resolved will have direct and dramatic effects on how physicians practice medicine. That's why legislators, often arbiters by default on public issues, must hear from physicians.

To help doctors make these important contacts, MSMS and the Michigan State Medical Society Auxiliary have created a program to bring doctors and legislators together. The 1993 Government Affairs Day this month will give lawmakers a chance to brief physicians on what's happening. Doctors then can meet with legislators to express their thoughts on the issues. The program will take place at the Lansing Civic Arena March 23, with physician visits to lawmakers' offices during mid-afternoon. Call Greg Aronin at MSMS at (517) 336-5739 for further information.

Maternal/perinatal health topics at MSMS March conference

Physicians interested in maternal and perinatal health should take note of an MSMS conference in Lansing later this month. The annual MSMS Conference on Maternal and Perinatal Health on March 24-25 will center on "The Perinatal Challenge." Courses on infant mortality, child abuse and neglect, immunization of preterm newborns and trauma in pregnancy will supplement other clinical sessions on obstetrics and pediatrics. The program provides up to 11 hours of Category I CME credit. Call the MSMS Office of Physician Education at (517) 336-5784 to register.

MSMS CLIA seminars will teach doctors about new requirements

Physicians who perform in-office laboratory testing of human specimens for diagnosis and treatment now are regulated by federal law. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) took effect last year. MSMS is conducting CLIA seminars in April and May to help physicians comply with these new federal requirements. The sessions will review the law and provide details on complying with quality assurance, quality control, proficiency testing and personnel requirements.

Watch for them April 19 in Flint, April 20 in Detroit, April 21 in Kalamazoo, May 11 in Grand Rapids, May 12 in Traverse City and May 13 in Marquette. Call the MSMS Office of Physician Education at (517) 336-5784 to register. You may also call MSMS Regulatory Ombudsman Tom Wolff at (517) 336-5740 with specific questions on CLIA.

MSMS to conduct pain management seminars

The MSMS Committee on Bioethics, with the sponsorship of the MSMS Committee on Aging, has developed a seminar for physicians on pain and symptom control in terminally ill patients. The seminar is designed to help physicians address alternatives to assisted suicide. The first seminar will be held in Kalamazoo April 13. Call the MSMS Office of Physician Education at (517) 336-5784 for details.

For details on these and other issues call William E. Madigan, Executive Director, MSMS, 517/337-1351.

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MEDICAL NEWSFRONTS

MDPH study of anti-smoking/AIDS prevention efforts released

State Health Director Vernice Davis Anthony recently released the findings of a statewide analysis of the department's AIDS prevention and anti-smoking media campaigns created by Brogan and Partners Advertising of Detroit. The purpose of the evaluation, conducted by Moore and Associates, Inc., Southfield, was to determine what impact the campaigns were having on their intended target audiences. According to the findings, awareness levels for both campaigns remain relatively high. More importantly, the number of calls to the state's AIDS prevention and anti-smoking hotline numbers have increased sharply since the campaigns were first launched in 1988 and 1989 respectively. The campaigns are a part of a comprehensive plan to reduce the incidence of preventable diseases in Michigan.

"I'm pleased with the findings of the evaluation and am confident that the advertising strategy has played a significant role in helping us to increase public awareness of the health risks associated with certain behaviors," said Anthony. "Our goal is to prevent disease by encouraging and promoting the adoption of healthier lifestyles among all Michigan residents."

Historically the state has had one of the highest smoking rates in the nation. As a result, more than 15,000 Michigan residents die each year due to tobacco related illness. To address these concerns, a statewide campaign aimed at encouraging smoking cessation and tobacco avoidance especially among urban women, minorities, adolescents and pre-adolescents was created. Findings from various primary and secondary sources indicate that significant progress is being made in this area. According to the Smoking Prevention Campaign evaluation:

- There has been a slight decline, the first in several years, in the number of Michigan citizens who smoke, from 29.2 in 1990 to 27.9 in 1991.
- Verified advertising recall is highest among children 10-17 years old and young adults between the ages of 18-24.
- 70 percent of people surveyed say the advertising campaign is effective in getting people to think about quitting or not starting smoking.
- The number of calls to the smoking hotline has more than tripled from 1,700 in 1989 to 5,500 in 1991.

Positive results were also achieved by the Michigan AIDS Prevention Campaign. Since 1981, over 3,300 Michigan residents have been diagnosed with AIDS. Another 15,000 are believed to be infected with HIV, the virus that causes AIDS. Despite these figures, Michigan is considered to have a relatively low rate of HIV and AIDS infection. Health officials attribute this to the overall effectiveness of the department's HIV/AIDS prevention strategy, including the media campaign. Results of the recent evaluation show:

- In a statewide advertising tracking study, more than six in ten Michigan residents reported that they knew about the AIDS hotline.
- As with the smoking campaign, available evidence shows a strong and direct correlation between the AIDS media campaign and hotline utilization. Since 1988, there has been a 64 percent increase in calls to the hotline.
- In an important measure of campaign effectiveness among those claiming recall, 18 percent noted that they changed their behavior as a result of exposure to this and other AIDS prevention efforts. This percentage equates to roughly 840,000 Michigan citizens.
- Evaluation findings suggest a positive impact between campaign exposure and accurate information about HIV and AIDS.

For additional information or a copy of the evaluation report(s) please contact Denise Holmes at (517) 335-9371.

Bulimia nervosa linked to brain hormone, U-M study indicates

Bulimia nervosa is associated with excessive levels of the brain hormone vasopressin, according to a National Institute of Mental Health study conducted by a University of Michigan Medical Center researcher.

The finding may lead to the development of effective medications for people with the disorder. The disorder strikes two to five percent of adolescent and young-adult women.

Mark A. Demitrack, MD, an assistant professor of psychiatry at the U-M, and colleagues at the NIMH examined the cerebrospinal fluid of 24 female patients with bulimia nervosa and 11 healthy female volunteers. On average, they found abnormally high vasopressin levels in the bulimic patients.

Vasopressin in the central nervous system is thought to affect thirst, blood pressure, learning and memory. The brain hormone is normally released in response to physical and emotional stress; an overabundance of vasopressin may put people at a higher risk for developing obsessive-compulsive illnesses such as bulimia nervosa.

AMA sets health reform strategies for 1993

With the election of President Clinton and the new Congress, the American Medical Association and the federation will have both opportunities and challenges regarding health policy. Many aspects of Clinton's proposals for health system reform are consistent

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Continued from page 9

with the AMA's own Health Access America. AMA leaders have already held discussions with Clinton's health transition team. The AMA wants to enhance physician involvement in public and private regulation of medical care, encourage implementation of market-oriented reforms, and prevent adverse patient care that would result from price controls or stringent global budgets.

Health Access America. In any reform plan, the AMA will continue to advocate key principles contained in Health Access America. The AMA will be a very aggressive advocate for patients and their physicians.

Federation Unity. Nearly all state medical associations have endorsed Health Access America while some national specialty societies have developed their own health care reform proposals. The AMA will emphasize similarities to allow intensified coalition-building during the next critical months. Unity on key health reform principles will provide physicians with strategic leverage with the Administration and Congress.

Managed Competition. President Clinton appears to favor managed competition where insurers, hospitals, and physicians would be encouraged to develop local "health networks." The AMA will:

- develop policy specifications to make sure the AMA remains at the forefront of the managed competition debate.
- lobby to include acceptable provisions and modify objectionable proposals.
- help physician members respond to managed competition.

Negotiations. The AMA will continue to seek relief from the antitrust laws to allow physician negotiation with both the federal government and private sector, and to pursue self-regulation.

Thanks to long-term advocacy of health system reform, the AMA and the federation are well-positioned and well-equipped to be key players in the forthcoming debate.

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PHYSICIANS IN THE NEWS



Kenneth E. Rowe, MD,
Hancock, has been appointed by the Governor to serve on the Michigan Technological University Board of Control. Doctor Rowe is currently medical director of the Western Upper Peninsula and Dickinson-Iron health departments.

The Oakland County Medical Society
has elected the following officers for 1992-1993: **Kenneth W. Gitlin, MD,** president; **Murray B. Levin, MD,** president-elect; **Stanley A. Dorfman, MD,** secretary; and **Peter T. Muller, MD,** treasurer.

Paul D. Stein, MD,
is the newly-appointed president of the American College of Chest Physicians. Doctor Stein is director of cardiovascular research and medical director of the LeVine Cardiac Rehabilitation Unit at Henry Ford Health System. He also is adjunct professor of physics at Oakland University.

James Scheiman, MD,
is a recipient of the 1992 American Gastroenterological Association/SmithKline Beecham Clinical Research Award. Doctor Scheiman, who is assistant professor of medicine, Division of Gastroenterology, at the University of Michigan, is one of six clinical researchers sharing the $150,000 award. His grant will be used to develop a human model representing the healing process of an ulcer. The model will help determine the role of growth factors produced in the stomach as well as the effect commonly taken drugs have on the healing process.

Shirley Robertson, MD,
Mason, is one of several physicians throughout the county invited to participate in a first-of-a-kind research project. She will serve as a physician-investigator in the Boston University Fever Study - a nationwide study that will examine the safety of medications commonly used to treat fever in children. The study was requested from the US Food and Drug Administration.

Joan Copeland Stryker, MD,
is the recipient of the 1992 Ellen G. Martin Award for Humanitarian Service. The award was given to Doctor Stryker in recognition of her many contributions to women's medicine. She was the first woman resident to graduate from the University of Michigan's obstetrics and gynecology program and went on to be a Founding Fellow of the American College of Obstetricians and Gynecologists in 1952. Although retired, Doctor Stryker is still finding ways to improve women's medicine in the area of menopause.

Douglas A. Mack, MD, MPH,
will serve in the second annual Public Health Leadership Institute. The purpose of the Institute, funded by the US Centers for Disease Control and Prevention and conducted by the CDC and the Western Consortium for Public Health, is to strengthen America's public health system by enhancing the leadership capacities of city, county, and state public health officials. Doctor Mack is the Public Health Director at the Kent County Health Department, Grand Rapids.

Kent County Medical Society
has elected the following officers for 1992-1993: **James A. Surrell, MD,** president; **Douglas A. Edema, MD,** president-elect; and **David E. Scheeres, MD,** secretary-treasurer.

Kathryn J. Wimbish, MD,
is a newly-elected member of the Board of Trustees for the Michigan Cancer Foundation. Doctor Wimbish, who is chief, Section of Breast Imaging, Department of Diagnostic Radiology, William Beaumont Hospital, previously served as secretary to the MCF's Regional Board for South Oakland County.

Federico Mariona, MD,
is the newly-appointed chairman of the Department of Obstetrics and Gynecology, Providence Hospital, Southfield. Doctor Mariona previously served as director for the Division of Maternal/Fetal Medicine, Oakwood Hospital.

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Cover Story

Preventive Health Care The important role of physicians





By Betty J. McNerney, Editor

When MSMS conducted a series of focus groups last fall as part of its "Medicine in the Year 2002" project, many of the physician participants said they looked forward to an era in which they would be much more involved in the prevention of disease, injury, and other public health problems. By becoming more involved in prevention, they said, physicians could help to control escalating health care costs, create a healthier society and improve their image. Most physicians expressed a sense of urgency, though, that physicians need to begin to intervene in areas of prevention right now. This month's cover story explores, in depth, one key public health program in which Michigan physicians can play a fundamental role right now -- the Public Health Breast and Cervical Cancer Program. As the following report indicates, Michigan's overall mortality rate from breast cancer is higher than the national average. In addition, about 600 Michigan women are diagnosed with invasive cervical cancer each year and 150 women will die from the disease. It is estimated that one-third or more of the deaths from breast cancer, and virtually all the deaths from cervical cancer, could be prevented through annual screening and appropriate medical follow-up of any abnormalities. Take time to read this report and then decide how you can become involved in this important program.

Also included in this month's cover story is an article about MSMS President-Elect Gilbert B. Bluhm, MD, and his interest in preventive health care, an area which will serve as a key theme throughout his term as MSMS president, which begins this spring. Rounding out this month's cover story is a report from the MSMS Department of Medical Economics and Health Care Delivery on "Cancer Incidence Among Michigan Residents 1989."



The Public Health Breast and Cervical Cancer Program

OUR ROLE AS PHYSICIANS

By Robert Allaben, MD, Robert Boorstein, DO and Brian Youngs, MD

In July 1991, the Michigan Department of Public Health received a five-year, $3 million-per-year grant from the US Centers for Disease Control under a new federal law (P.L. 101-354, adding the Title XV amendment to the Public Health Service Act), to implement a women's breast and cervical cancer control program. With these funds, local health departments are now able to provide low-income women aged 40 and older access to cancer screening services and follow-up care. The program is currently available in 50 counties in Michigan and, if additional federal funds are forthcoming, is expected to be available statewide by the end of 1994.

Local physicians are being asked by the health departments to enter into partnerships with public health providers to see that each woman receives appropriate care. Questions have been raised by physicians regarding the nature of the program, and the advisability of serving as referral physicians for the public health department. It is the intent of the authors to explain the program and encourage community physicians to participate in the breast and cervical cancer control program.

The problem

Michigan's overall mortality rate from breast cancer is higher than the national average. Almost 6,000 Michigan women are diagnosed (5,902 in 1990) and more than 1,600 (1,619 in 1990) women die every year from breast cancer. The problem of premature breast cancer mortality is greater for African American women even though the disease occurs more frequently in white women.

1. Localized - invasive cancer confined to the organ of origin.

2. Regional - direct extension to adjacent organs or tissues or involvement of the regional lymph nodes.

3. Distant - direct continuity to non-adjacent organs, discontinuous metastasis or involvement of the distant lymph nodes.

About 600 Michigan women are diagnosed with invasive cervical cancer each year and 150 women will die from the disease. The incidence rate among African American women is more than 70 percent higher than the rate among white women. The age-adjusted death rate among black women is approximately 2.5 times higher than the rate among white women. Women aged 50 and older are much more likely to have later stages of cervical cancer at the time of diagnosis than younger women. African American women, regardless of age, are more likely to have later stage disease at diagnosis.

Many of these 1,750 deaths from breast and cervical cancer preventable. Screening tests with acceptable specificity and sensitivity are available for both cancer sites and clinical trials have demonstrated early detection reduces mortality. It is estimated that one-third or more of the deaths from breast cancer, and virtually all the deaths from cervical cancer, could be prevented through annual screening and appropriate medical follow-up of any abnormalities. It is especially important to increase screening of older women, minority women, and low-income women because they are least likely to get mammograms and Pap smears, and most likely to die from breast or cervical cancer.

Telephone surveys of women indicate the three most often cited reasons that women do not obtain a screening mammogram, according to the National Cancer Institute and American Cancer Society guidelines, are lack of a physician's recommendation, perceived lack of personal risk, and the cost of the procedure. Until this federally-funded program was available, low-income uninsured women aged 40 or older could not afford the cost of the preventive screening tests. The costs of screening mammography alone range from $50 to more than $250 in Michigan. Even among insured women, screening may not be covered. Regardless, both tests require the services of a provider.

The federal/state program

Michigan is one of 12 states that have received the federal funding under the Breast and Cervical Cancer Mortality Prevention Act. The law is administered by the Centers for

Disease Control. A requirement of the funding is for each state to put into place a statewide comprehensive program of breast and cervical cancer control. The seven required components of the program are described below.

■ **Screening Services.** The majority of the federal funds are intended to pay for the screening services for low-income women. Each agency must install a sophisticated tracking system to assure that each woman proceeds through the screening process in a timely manner and, if an abnormality is found, she is provided with timely and appropriate referral and follow-up care. Services available through these new local public health programs to low-income women aged 40 and older are:

- clinical breast exams;
- pap smears;
- pelvic exams;
- screening mammograms; and
- appropriate referrals to community physicians for follow-up of abnormalities, if indicated.

The schedule being used for screening is:

Breast Cancer Screening:
Women aged 40-49:

- Clinical breast exam every year, and
- Mammographic screening every one to two years.

Women aged 50 and older:

- Clinical breast exam every year, and
- Mammographic screening every year.

Cervical Cancer Screening:

- Pap smear and pelvic examination every year, but after three or more consecutive annual examinations that are normal, the Pap test may be performed at three-year intervals, at the physician's discretion.

This new federal grant program is targeted especially at low-income women aged 40 and older. With these funds, health departments can provide screening services at no cost to uninsured women whose incomes are at or below the federal poverty level; and reduced-cost services for uninsured women whose incomes range up to 250 percent of the federal poverty level.

Women with insurance also can be served by this program, but their insurer will be billed for services provided. If their insurance does not cover one or more of the services, and they meet income eligibility criteria, they may be eligible for free or reduced-cost services. Women with the ability to do so will be encouraged to seek screening and follow-up services from their private physicians.

■ **Follow-up Services.** Diagnostic and treatment services must be available in the community to women who are found to have an abnormality through screening. Use of these federal funds to pay for most diagnostic, and all treatment services is prohibited by the federally enacted law. Therefore, public health agencies must make arrangements for these services within the community to ensure that women with a diagnosis of breast or cervical cancer will receive treatment.

Depending upon a woman's medical need and her financial and insurance status, federal grant funds also may provide:

- diagnostic mammograms;
- fine needle aspiration
- colposcopy services; and
- colposcopy-directed biopsy services.

■ **Public Education.** The Michigan Department of Public Health in partnership with the Michigan Division of the American Cancer Society, has implemented a major education and media campaign. The activities are directed to women 40 years old and older with special messages to the groups at greatest risk: minority women, elderly women, and women with sparse financial resources. The message is to seek screening from their personal physician or their local health department. Posters and brochures (available from the MDPH) have been placed in public places frequented by the target populations, and radio and television spots began airing February 1.

■ **Professional Education**. The State Health Department has established panels of experts to advise state and local staff on all aspects of the cancer control program. Several representatives from medical specialty societies, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan State Medical Society, county medical societies, and local health department health officers serve on these advisory committees. A major role of the committees is to help disseminate information about breast and cervical cancer control throughout the physician community, and to help physicians and other health professionals realize the truly crucial influence they have on whether or not their patients and clients decide to obtain screening. Activities in professional education are coordinated closely with the quality assurance requirements.

■ **Quality Assurance**. With the advice and direction of the advisory groups, the state program is mandated to improve or maintain high quality breast and cervical cancer screening services throughout the state. Mammography facilities that provide services to women through the state cancer program are required by the CDC to be accredited by the American College of Radiology and, by federal law, must meet all additional federal and state requirements. Mammography facilities must obtain a federal Health Care Financing Administration provider number to be a screening mammography supplier for Medicare. Similarly, cytology laboratories must comply with the federal Clinical

Continued on following page

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Laboratory Improvement Amendment requirements as well as all state regulations. Each clinician conducting the screening examination will have the opportunity to receive additional skills training in clinical breast examination and collection of the pap smear.

■ **Surveillance and Evaluation.** The state is required to build a data system that will allow extensive evaluation of each of the seven components. The process and outcomes of the program will each be monitored and data will be analyzed about the timeliness of care, the effectiveness of the educational programs in changing behavior of both professionals and the public, and the ability to recruit women in the targeted populations to screening. Screening rates, staging data and, ultimately, mortality rates will indicate the overall effectiveness of the comprehensive program. The data collected in the program will help identify additional areas where professional education activities might be indicated as well as strengths and weaknesses of our quality assurance programs.

■ **State Planning and Coalition Building.** As new issues arise in the control of breast and cervical cancer, the state and local advisory groups will assist the department to implement and/or revise the goal-oriented state cancer plan so that the public health objectives may be met. The ultimate objective of the breast and cervical cancer control program is to increase the percent of cancers found at the localized stage, to reduce overall mortality rates and to, hopefully, eliminate the gap between mortality rates of white and African American women.

Physician participation

Assistance from the physician community with each of the seven components is essential if the outcomes are to be met. First of all, all primary care physicians should actively encourage all women to undergo screening mammography, have regular breast examinations, and obtain pelvic examinations with a Pap smear at the recommended intervals throughout their life. Physicians who care for indigent women who do not have resources to pay for one or more of the screening exams may refer them to the local health departments in participating communities for these services.

In order to qualify for a federal grant to offer this screening program, local health departments must enlist the cooperation and participation of physicians, hospitals, and other health care organizations to assure that all necessary screening and follow-up services are provided. Local health departments are required to provide or arrange for basic screening services – clinical breast exams, screening mammograms, pelvic exams, Pap smears, and patient education. Some departments are delivering most of these basic services through their existing or expanded department staff, usually Certified Nurse Practitioners experienced in family planning or adult medicine programs. Other departments are providing the basic services through subcontracts with community physicians or nurse practitioners. Local health departments are entering into contracts with American College of Radiology-accredited radiology facilities to provide mammography services to enrolled women. The federal grant also requires an extensive patient data and tracking system to be in place to ensure appropriate follow-up of abnormalities and encouragement of routine re-screening; coordination of this tracking system is the responsibility of the local health department.

No health department can offer screening services without having first identified community physicians who agree to provide diagnostic and treatment services to all women in the program who need it, regardless of insurance status or ability to pay. The law, unfortunately, stipulates that funds may not be used to pay for any services other than those listed above. This means that local health departments must convince community physicians and hospitals to assume the financial responsibility for care of some indigent women who are diagnosed with breast or cervical cancer.

Community providers

Mammography facilities are needed that have their machines accredited by the American College of Radiology, are certified by Health Care Financing Administration (HCFA) as a supplier of screening mammography, and have met all inspection requirements of the Michigan Department of Public Health (MDPH). Participating mammography facilities will provide screening and diagnostic mammograms for women enrolled in the federally funded screening programs. Mammography is reimbursable under the federal program. The reimbursement rate for mammography for women enrolled in this program is the same as the Medicare-approved rate for this service.

Laboratories are needed that are located and licensed in Michigan and that have met all federal and state inspection requirements. Participating laboratories will review and interpret Pap tests and cervical biopsies for women enrolled in the screening program. The examination of the Pap smear and the biopsy specimen obtained by colposcopy or needle aspiration of the breast are reimbursable under the federal program.

Physicians and health care facilities are needed to provide diagnostic and treatment services to women enrolled in the screening programs who are identified with abnormalities. Colposcopy and colposcopy-directed biopsy and fine needle aspiration of the breast are the only diagnostic procedures which may be reimbursed through the federal program. Physicians are needed who can provide additional types of breast biopsy and the various types of treatment (breast surgery, gynecological surgery, anesthe-

sia, radiation oncology, medical oncology) for women diagnosed with breast or cervical cancer through the federal program. In-patient facilities must be available that will admit women regardless of the woman's ability to pay for services. In addition, local community physicians who would be willing to serve as preceptors for and consultants to health department staff will be sought by the state advisory panels.

Why participate?

This program offers physicians a unique opportunity to join together in a partnership to prevent unnecessary deaths among Michigan's families and communities.

Although local health departments will target their marketing efforts for this program to low-income women, they also will be encouraging all women to be screened. The state health department's statewide public education and media campaign encourages regular screening by all women. As a result of these marketing and education efforts, all community physicians should see increases in requests for screening and follow-up services. Women who are able to do so will be encouraged to go to their personal physicians or to participating community agencies for both screening and follow-up services.

Issues of concern to physicians have related particularly to the government's shortsightedness in not providing compensation for treatment and potential liability problems. Unfortunately, this law specifically excludes payment for definitive care. However, as physicians, we should make every effort to see to it that these patients are treated appropriately. The number of such patients identified will not be very large. If many physicians and institutions agree to care for such patients the burden will be spread more evenly. Data identifying the number of hours and dollars that are being provided for uncompensated care will be collected and utilized as an argument to the government to establish some type of fund for payment of definitive care of patients unable to compensate their physicians and institutions. Since Hippocrates, we as physicians have all had the responsibility to see to it that patients receive appropriate care despite their ability to pay for the services. We also need to strive to adopt programs which will provide compensation for services for patients such as these. If all of us accept such responsibility, the burden will not be undue on any single individual or institution.

Recent studies have documented that the perception that impoverished and low-income patients sue physicians and hospitals for professional liability more commonly is, in fact, not true. These studies point out that actually this group of patients is somewhat less likely to sue their physicians. Therefore, physicians are encouraged to participate in this federally funded breast and cervical cancer control program so that these currently underserved women have an opportunity to be treated at an early stage of their disease.

It is not yet possible to predict how many women in this target population of indigent women ages 40 and older will require further evaluation and treatment. Some data are available regarding breast abnormalities found through screening. Data from cervical screening come primarily from family planning programs where the women are much younger. What follows are general guidelines; actual experience will vary depending on the population being screened.

The literature suggests that for every 1,000 women screened with mammograms plus clinical breast exams, an estimated 50 to 70 women will require additional diagnostic evalua-

Continued on followng page

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Continued from page 19

tion. Of those women, an estimated two to seven will have breast cancer.

Based upon a review of existing literature and the expert opinions of Michigan epidemiologists and cancer specialists, it may be expected that for every 1,000 women aged 40 and older screened with Pap smears, an estimated 10 to 20 women will require some type of medical follow-up. Of the women with initial abnormal Pap smears, three to five women will be diagnosed with cervical cancer.

It is important to remember that only a small percentage of the women enrolled in the program who are diagnosed with breast or cervical cancer will not have any ability to pay for diagnostic and treatment services they need. These women, however, will need the help and donated support of community physicians and facilities who can provide the care they need.

Summary

Through a federally funded breast and cervical cancer control program, women who have breast or cervical cancer should be identified at earlier stages of their disease. Working together, community physicians and local health departments can ensure that the highest quality breast and cervical cancer control services are available to all women in their communities. This public/private partnership will help ensure the survival of these crucial members of our families and communities - our mothers, grandmothers, wives, sisters, daughters, friends, and co-workers.

For information about the location of participating local health departments, please call the Michigan Department of Public Health Mammogram Hotline at 1-800-922-MAMM (1-800-922-6266). For media materials or for more information about becoming involved as a provider of services for community breast and cervical cancer screening programs, call (517) 335-9161.

All women are at risk of developing breast and cervical cancer. Please do what you can to encourage *all* women to obtain screening according to the schedule recommended by the American Cancer Society and the National Cancer Institute. And please cooperate with your local health department when your community initiates this program.

References available upon request.

Doctor Allaben is chief, Department of Surgery, Grace Hospital, Detroit. He is a provider of surgical services to women enrolled in the Detroit City Health Department BCCCP. Doctor Boorstein is senior consulting surgeon, Botsford General Hospital, Farmington Hills. He has agreed to provide surgical services to women enrolled in the BCCCP from Southeastern Michigan. Doctor Youngs is medical director and health officer for participating District Health Departments Numbers 3 and 4 covering eight counties in the northern lower peninsula. All three physicians are members of the Michigan Breast Cancer Task Force.

Good health can come from education, prevention.

MSMS president-elect targets youth

By Claudia R. Skutar

Good health is often a matter of prevention. Avoid cigarette smoking and you can lower your risk of heart and lung disease. Consume alcohol in moderation, and you can help prevent unnecessary injuries and deaths caused by drunk drivers. Take precautions in having sex, like using condoms, and you can reduce your risk of getting AIDS, or other sexually-transmitted diseases.

These ideas may seem like common sense, especially to physicians. Yet, we all know that sometimes the things that seem most simple are most difficult to achieve. And if it's difficult for adults to set preventative habits for their good health, what about kids and teens?

This is a question that MSMS President-Elect Gilbert B. Bluhm, MD, is familiar with. The busy Troy rheumatologist is concerned about the health of his patients, but that interest extends beyond treating their diseases in his office.

"It's important for the public to know that doctors are interested in rendering care and comfort to patients, but it's also important to address health issues important to our communities," said Doctor Bluhm. "Patients don't just need short-term health care, but long-term care with an emphasis on prevention."

He believes prevention should start early in life. "It's better to get someone to form good health habits while they're young," he said. That's why he wants to find ways to help promote adolescent health.

It's at this point that Doctor Bluhm's medical interests intersect with his involvement in Detroit's "City for Youth" project. The project uses TV programs to educate people about the quality of life for Detroit's kids and teens. Detroit public television station WTVS (Channel 56) has spearheaded the project since its birth more than two years ago.

Finding fertile ground, the project quickly flourished. More than 400 community groups and businesses banded together to form a "City for Youth" Coalition. A planning committee was created to advise WTVS on implementing the many related community activities sprouting up.

A group of physicians and health professionals also was formed to provide advice on TV program content. Their input was especially effective since the 1992 "City for Youth" theme was "The Health of Our Children." Doctor Bluhm was among those physicians who advised which health issues should be addressed.

An outgrowth of this television programming was creation of a health education video series aimed at teachers and students. The classroom videos and accompanying discussion guide are designed to help middle and early high school students learn healthy behaviors. The 20 videos are two to four minutes long and cover substance abuse, stress and depression, AIDS, and peaceful conflict resolution.

The video formats vary. They include documentary-style stories about young people, and parodies of game shows, sitcoms, commercials or talk shows.

What's especially good about them, notes Doctor Bluhm, is the videos show young people talking about their health issues, not physicians, nurses or adults. That makes the videos more effective.

"If these students see their own peers talking to them, it may help them to become more responsible for their own health," he explained.

Doctor Bluhm believes so firmly in educating young people about good health that he wants to see the videos distributed to every middle and high school in Michigan. They've already been provided to schools in southeastern Michigan.

To help get them into schools statewide, Doctor Bluhm went to the MSMS Health Education Foundation (HEF) in February to ask for a $10,000 grant. HEF each year uses money contributed by Michigan physicians to provide applicants with grants to help educate people about good health. The foundation said yes to his request.

Doctor Bluhm is happy about that. That's because it goes hand-in-hand with one of his primary interests--getting good health education material out to Michigan youth.

Claudia Skutar is communications specialist for MSMS.



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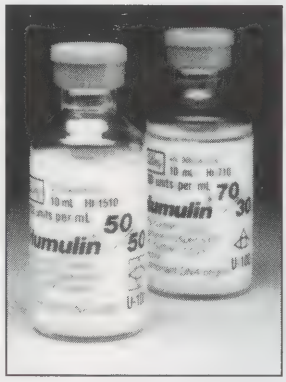
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Public health a top MSMS priority for 1993

Public health ranks among the top priorities of MSMS for 1993. Specifically, MSMS plans to:

- Emphasize disease prevention through liaison with the Michigan Department of Public Health.
- Promote healthy lifestyles for youth including the areas of violence, AIDS and other STDs, substance abuse and mental health.
- Support tobacco tax increase.
- Work with the Michigan Department of Public Health to address Michigan's high infant mortality rate.
- Fight for the survival of rural practices, hospitals and clinics.
- Continue to develop Medicare "Senior Courtesy Card Programs."
- Work to identify and improve environmental health risks.
- Strive to lessen the incidence of family violence through the efforts of the MSMS Task Force and Forum on Family Violence.

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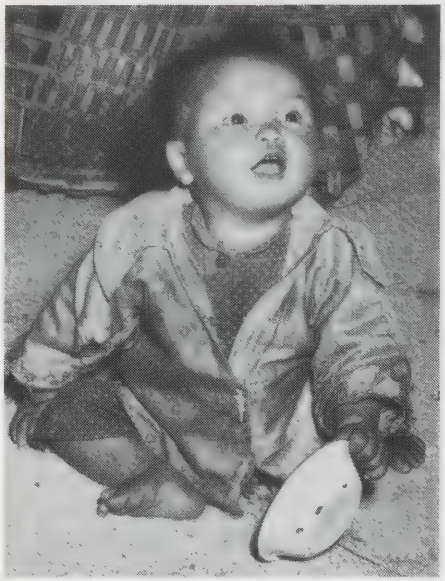
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These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). 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Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS from the MSMS Department of Medical Economics and Health Care Delivery

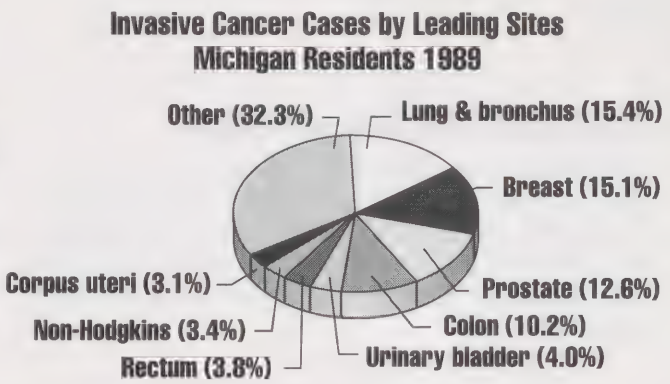
Cancer Incidence Among Michigan Residents 1989

In a previous issue of Medical Inquirer, a JAMA study on the incidence of nine chronic diseases was presented, showing Michigan to be a state with a serious chronic disease problem. In this issue, data from the Michigan Cancer Surveillance Program is presented to further illustrate the incidence of cancer in Michigan's population.

The registry facilitates epidemiological studies and planning and evaluation of cancer prevention and control programs. These data represent the approximately 34,000 cases of invasive cancer diagnosed in Michigan residents in 1989 and reported to the Michigan Department of Public Health by December 31, 1990. Additional cases may be identified and reported in later years.

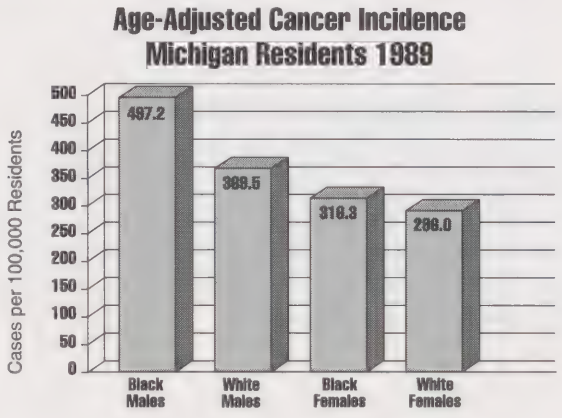
Invasive Cancer Cases by Leading Sites

Lung and bronchus, breast, prostate and colon were the four most frequently diagnosed sites in 1989. This ranking was the same as for cases diagnosed in 1985, but the gap between lung and bronchus and breast cancer narrowed. These four sites accounted for more than 18,000 cases, which was 53% of all cases diagnosed in 1989.



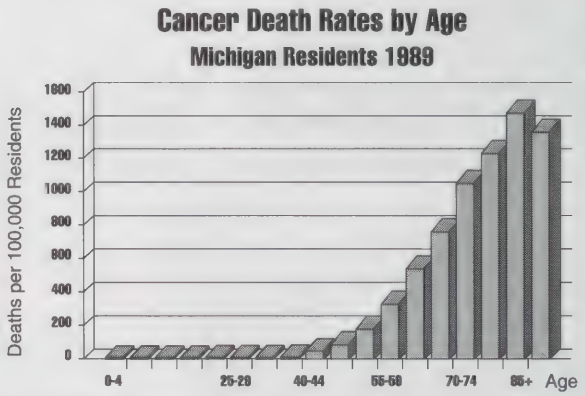
Age-Adjusted Cancer Incidence

Black males had the highest age-adjusted incidence rate in 1989. At 497.2 cases per 100,000 residents this rate was 35% greater than that of white males. The lowest incidence was observed in white females at 269.0, 6.9% less than the rate for black females. This pattern was consistent in the years between 1985 and 1989.



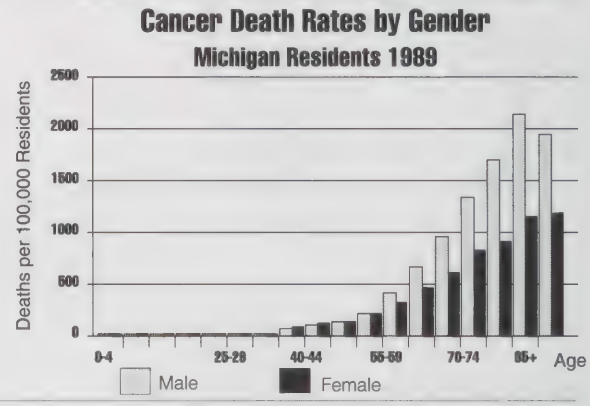
Cancer Death Rates by Age

There were 18,264 total deaths due to invasive cancer in 1989, which is 6% higher than 1985. Age 50-54 was a transitional age, with the age-specific death rate surpassing the rate of 174.2 for the total population. The highest death rate was between the ages of 80-84 at 1,492 per 100,000.



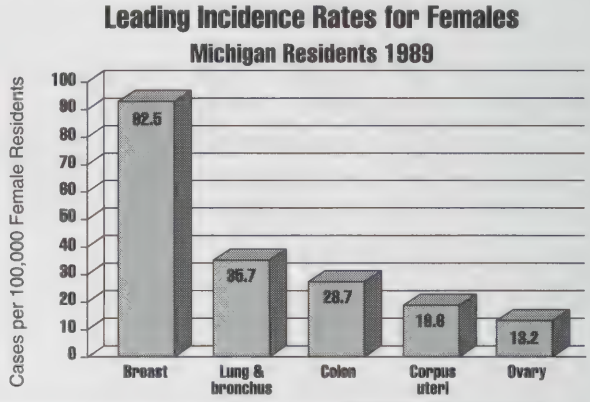
Cancer Death Rates by Gender

Males accounted for 53% of cancer deaths. At ages 55-59, male death rates began to exceed female rates, a margin that increased with age. By age 80-84 the male death rate was 86% higher than for females. The overall death rate was 145.8 for females and 214.3 for males.



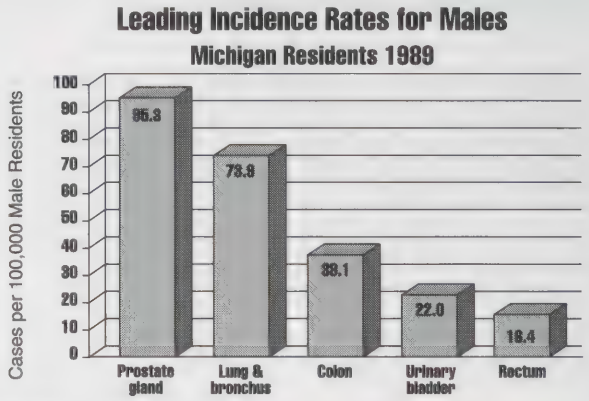
Leading Incidence Rates for Females

Breast cancer was the most frequent site of cancer in women, with 5,065 cases and an incidence rate of 92.5 cases per 100,000 female residents. Lung and bronchus followed at a distant second at a rate of 35.7. Breast, lung and bronchus, and colon represented 53% of cancer diagnosed in females in 1989.



Leading Incidence Rates for Males

Cancer of the prostate gland accounted for 4,272 cases in 1989 for an incidence rate of 95.3 per 100,000 male residents. Lung and bronchus was the second most frequent site, as it was for females, with 3,277 cases. The prostate gland, lung and bronchus and colon accounted for 54% of cancers diagnosed in males in 1989.



SOURCE: Michigan Department of Public Health. *Cancer Incidence & Mortality: Michigan 1989*. July 1991.

For further details on trends and sources of information, please contact Julie Lester at MSMS.



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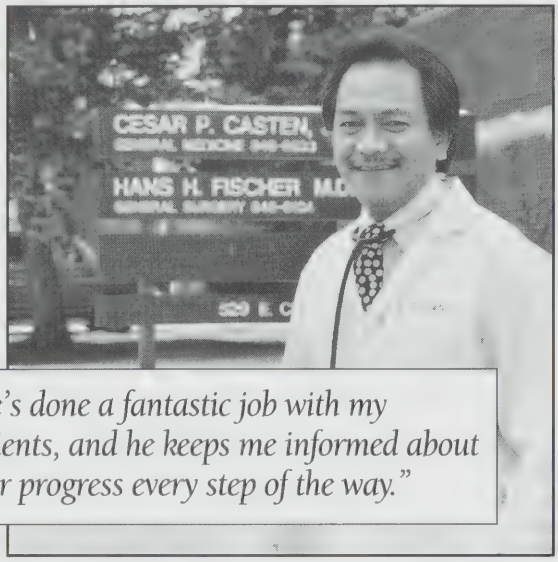
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SPOTLIGHT

Michigan Medicine is pleased to introduce this column which spotlights the activities of county medical societies. Each month, *Michigan Medicine* will delve into the activities of one county medical society. If you would like your county medical society featured on this page, please contact Helen Fordham at MSMS.

KENT COUNTY

Kent County mini-internship program helps demystify medicine

By Helen Fordham

Physician bashing is fashionable in some circles, to say the least. But, thanks to the efforts of the Kent County Medical Society, physician bashing may soon diminish, at least in some local circles.

The Kent County Medical Society recently held its second mini-internship program which showed a lawyer, a journalist and a businessman that physicians are caring, committed professionals.

"The internship provides the opportunity for the community to walk in our shoes," explains Charles R. Henry, MD, immediate past president of Kent County Medical Society. "Through shared experiences, this project is designed to open lines of communication and expand perspectives on important health care issues," he says.

The first internship was held in 1976 and it was met with great success. The AMA subsequently endorsed the program and The UpJohn Company provided an educational grant for promoting internship programs across the country. To date, there have been two programs held in Kent County and several in other Michigan counties.

Kent County had no difficulty in recruiting physicians to participate in the program, according to KCMS Executive Director Chip McClimans. The physicians are enthusiastic about the opportunity to share how strongly they feel about their profession.

"I am a member of a privileged profession because people open their lives to me," explains family practitioner James D. Hudson, MD, at the program orientation.

Doctor Henry sees it the same way. "That the patients trust you is such an awesome feeling of responsibility. It's such a privilege," he says. "The one-on-one relationship with patients is one of the greatest aspects of being a doctor; you get to share in someone's life."

The Kent County Medical Society has found it equally easy to attract interns. "We have drawn interns from the press, education and business," says McClimans. "Some have even contacted us directly, he adds, after hearing about the program," he adds.

Four interns were selected to be involved in the program held in January, including: Chris Meehan, medical reporter for the *Grand Rapids Press*; Bruce Neckers, attorney and past president of the Grand Rapids Bar Association; and Jerry VanderWal, benefits director for Meijer, Inc.

Each intern was assigned to four physicians from specialties ranging from primary care to emergency medicine. The interns spent half a day with their designated preceptors accompanying them on office visits, surgery or hospital rounds.

The interns are encouraged to ask questions and share their perspective of the medical system. It is an opportunity to share information and no subject is taboo, including physicians' salaries, liability or insurance.

A multidimensional view

Through exposure to different specialties, interns have the opportunity to view the profession in a multidimensional way. Each preceptor provides their own unique view of medicine.

Paul R. Mark, MD, a second-year obstetrics resident at Butterworth Hospital, spoke glowingly of his involvement with what is often the happiest moment in many people's lives - the birth of a baby. Asked about the liability climate, he admits he is worried and will look closely at opportunities in his home state of Illinois, where the laws are more favorable. He has no intention, however, of leaving his chosen specialty. "I won't let the liability climate tell me what I can do," he says.

Another who is equally committed to his specialty is ophthalmologist David D. Verdier, MD, who believes his specialty is not just about keeping someone going but about making a difference in peoples' lives. Through transplant operations and cataract removals, which make up the staple of his practice, he feels he can immediately impact the quality of a patient's life.

Brian V. Phillips, MD, also feels strongly about the importance of his role as a family practitioner. "The approval rate physicians have reflects approval of primary care physicians," he says. This approval is earned by caring about everything that is happening in a patient's life.

All the internship physicians were clearly dedicated to their profession and they were open to discussing the problems confronting medicine. Plastic surgeon David A. VanderWall, MD, spoke frankly of the silicone breast implant ban. He says he has never had any trouble with silicone

Continued on following page

Continued from page 29

but the number of patients asking for augmentation has radically dropped off. Yet he is more concerned about how the ban will affect other areas of medicine.

Butterworth emergency medicine physician Ralph N. Rogers, MD, faces a different kind of problem. Doctor Rogers, who has worked in emergency rooms for 12 years, spoke of the increasing trend for patients to use the emergency room as a primary care facility.

Internship a valuable experience

The experiences of each of the four interns varied but the impressions were the same.

"The overall learning experience is just how much physicians care," says Neckers, who found the experience taught him about the softer side of medicine. "I can't say anything more complimentary than that they (physicians) care about their patients."

The *Grand Rapids Press* medical reporter agreed. "I was taken aback by the caring," Meehan confides. "These are people who care, who really tried to help." At a debriefing he admitted he had learned a greater sense of appreciation for the job. "You give much more than I could have."

Each of the interns had more than a passing knowledge of the medical profession, yet they were surprised at some of the difficulties confronting physicians.

Neckers spoke of the shortage of emergency room facilities at Blodgett Memorial. "There were too many people in need of care and not enough room," he observes.

Meehan also notes that a lot of physicians are doing their job but patients are not following through. "Patients are not taking responsibility for their care," he says.

The 12 physicians involved in the internship program were equally positive about the experience. Doctor Hudson found the program helped re-inspire him. "The program helped me reflect on what I do," he explains. "It is easy to get overwhelmed in medicine and discouraged and sometimes you need to step back and look at what you do. Showing someone what you do helps do this."

How the public perceives the medical profession concerns these physicians. They applaud the opportunity offered by the internships. "Medicine is misunderstood and maligned and this is a great opportunity to get others to know about medicine," says Doctor Verdier. "There are a lot of misconceptions about being a doctor," he adds. "Most people have no idea how many hours doctors work; people don't realize what it's like to be a physician."

Gastroenterologist John P. Papp MD, concurred. "There is something wrong with the way the public is being manipulated into seeing doctors," he says. "No one talks about the free care patients get; we are providing free care all the time."

Kent County Medical Society President James A. Surrell, MD, plans to continue the mini-internship program, which he sees as an important communications tool. "It is critical for us all to learn to communicate," he says. "We need to develop physicians who can communicate with patients and we need to communicate with industry and with each other."

Helen Fordham is chief of community relations for MSMS.

Impressions of MSMS staff

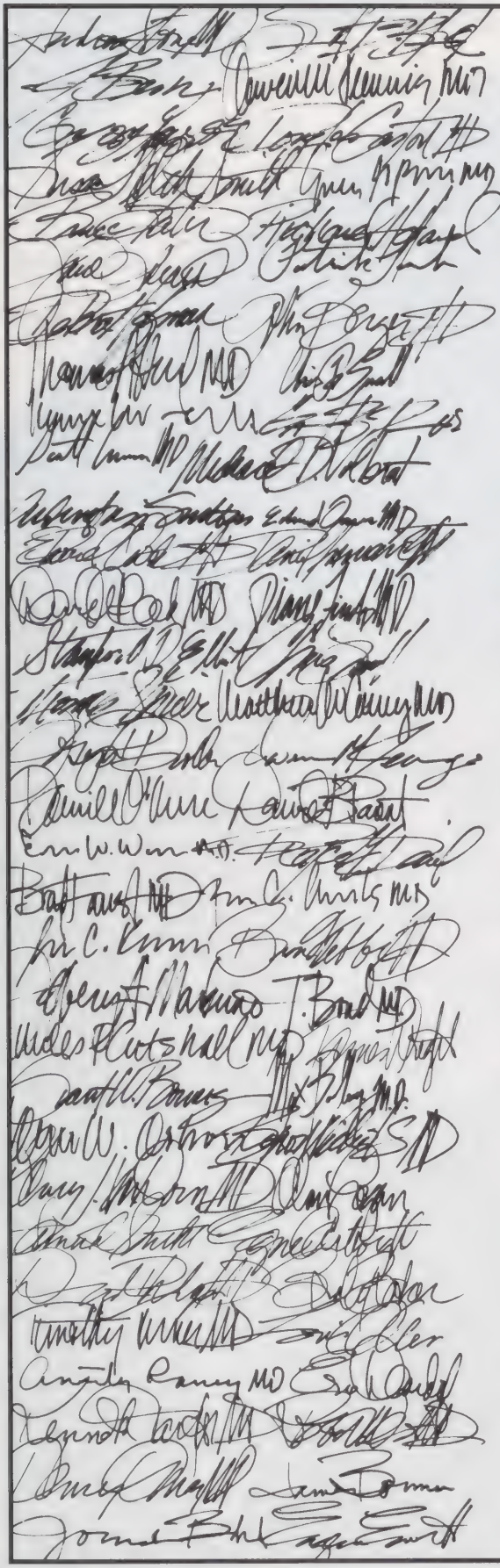
Editor's note: Following are the impressions of Helen Fordham, chief of community relations for MSMS, who participated in the Kent County Mini-Internship Program.

I watched with excitement as a baby was born, listened with apprehension as a woman was diagnosed with cirrhosis of the liver and felt totally helpless as a little boy sobbed as his lip was sutured. In the two days of the Kent County Mini-Internship Program I had seen a kaleidoscope of patients suffering ailments from head injuries to cataracts. My back ached and my arches were about to fall, yet this was a standard day for the physicians I accompanied.

I knew physicians were busy and smart before I started the program but I didn't know they were human. The internship program allowed me to see that they aren't all white coats and efficiency; they genuinely care about their patients. I watched as one physician thrust a bag of samples into the hands of a patient and told her not to worry about the cost of the visit since she was having financial difficulties. I listened as another physician patiently explained to a recently diagnosed MS patient the importance of getting a good lawyer to help with his battles with his employer. I was touched by the emergency medicine physician who gently examined a patient who smelled so badly it made me gag. And I was reassured to see how well patients were treated while under anesthesia.

As a physician advocate, I am familiar with some of the issues confronting medicine - the difficulties of reimbursement, the increasing regulation, liability. But I forgot all these issues must be placed in a human context and that whatever is decided in the abstract will directly impact patients.

The Kent County Mini-Internship Program served to remind me that medicine is about people and physicians working hard to care for them.



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Two Michigan physicians establish the American Russian Medical Exchange

By Helen Fordham



Shown from left to right are Doctors Fitzsimmons and Springer; Doctor Miheeva, head of the International Scientific Technical Cooperation; Doctor Gratchov, vice rector of the Moscow Academy, which trains 8,000 students; and a translator.



A typical intensive care unit in Russia.

"There is no doubt today (that Russians) want change. They know they need help and they know America will help. We have technology, education, organizational skills and supplies to export and they are now open and receptive to our overtures."

L.W. Fitzsimmons, MD

"We hope ARMX will help bring the Michigan State Medical Society, Michigan State University and the private sector together to provide a forum for the exchange of personnel and information with Russia...We got into this because our hearts are saying do it."

Dawn E. Springer, MD

Something special is happening in Lansing. International compassion has become tangible and the world a bit brighter from the glow of two more points of light.

Lansing orthopedic surgeon L. W. Fitzsimmons, MD, and Mason family practitioner Dawn Springer, MD, are working furiously to raise community interest in the newly-formed American Russian Medical Exchange (ARMX). They founded the program, which is designed to promote understanding and the interchange of medical services knowledge between medical communities in the two countries.

"We hope ARMX will help bring the Michigan State Medical Society, Michigan State University and the private sector together to provide a forum for the exchange of personnel and information with Russia," explains Doctor Springer.

The infant program, which grew out of the physicians' recent experience with the Russian medical system, has other goals. These include plans for on-going educational exchanges, setting international medical standards, and helping prepare physicians to serve in changing health care environments.

Doctors Springer and Fitzsimmons are so committed to the development of the exchange that, in spite of busy practices, they have devoted nearly one-third of their time over the last several months to canvassing local business, medical and educational groups for support. What is more, they have personally borne the administrative costs of creating the ARMX exchange, including two trips to St. Petersburg and Moscow in June and October 1992 to lecture on sports medicine and to continue their assessment of the humanitarian needs of the Russian medical community.

"We got into this because our hearts are saying do it," says Doctor Springer. "It is a horrendous drain on our energies but it is continuing to grow because of our personal desire."

"It is difficult to explain what drives us to work so hard on this program," speculates Doctor Fitzsimmons. "But it was impossible not to have admiration for the Russian people's resilience, he adds, and to be touched by their need."

How it all began

The impetus for the ARMX exchange came from the doctors' first visit to Moscow and St. Petersburg in June 1992. Doctor Fitzsimmons was invited early in the year by the president of the Unified All Russia Federation of Sports Medicine, Lev Markvo, MD, to visit the Moscow Sports Clinic. At the same time, Doctor Springer was selected to be a member of the Lansing Delegation sent to St. Petersburg as part of the sister city program. The physicians coordinated their trip and spent two weeks touring several hospitals where they witnessed the conditions under which patients receive health care in Russia.

"The system is incomparable to anything I know or have experienced," says Doctor Fitzsimmons. "It's a highly structured system, bureaucratically conceived and tightly controlled, that has resulted in almost virtual paralysis within the country." He adds: "Except for the obviously sick and injured, it is my impression that the health system is relatively unavailable to the average citizen of Russia."

The total lack of support systems has resulted in chronic shortage of supplies, according to Doctor Fitzsimmons. "The personnel are well trained," he explains, "but they are nearly impotent to provide the services for which they have been trained due to the lack of supplies and equipment."

While in Russia, the two physicians helped coordinate the distribution of supplies sent by Lansing-based Sparrow and St. Lawrence hospitals, which partially sponsored the doctors' trip.

"We weren't really aware of how great the need (for supplies) is," says Doctor Springer. "We were treated like gods and we were just providing basic items." The physicians learned that Russian hospitals do not have disposable syringes and if they do they are reused. Items as simple as

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tape are in short supply.

It is impossible for hospitals to maintain sterile conditions because of the shortage of supplies, explains Doctor Fitzsimmons. The Russians don't have sterile scrub sponges or sterile gloves for surgeons.

In addition to the shortage of supplies, there is very little post operative care. The physicians observed patients being returned to their hospital room without any recovery care. Little attention is paid to sterile techniques during surgery, says Doctor Fitzsimmons, and monitoring during the operation is often little more than blood pressure and pulse. The Russians have very little technology. The machines they do have are antiquated and scarce, and if they break there are no replacements.

Yet this system of socialized medicine, which is technically free to Russian citizens, sees other patients remaining in the hospital for up to six weeks for injuries as minor as a sprained knee, says Doctor Fitzsimmons. Their stay is free, so patients remain in the hospital until they are completely recovered.



A private hospital room in Russia can be obtained by buying insurance at 30 rubles per year. With the insurance, a patient can receive a room with four beds or less, disposable needles and syringes, a nurse (shown above), and a guarantee against contracting the AIDS virus.

In spite of the inadequacies of the Russian system, Doctor Springer feels there is much American physicians can learn. "They have many skills and remedies from which we can benefit," she explains. The hospitals are so lacking in medical supplies and technology that Russian medicine has focused on an early traditional medicine. Doctor Springer described how one sanitarium used herbal remedies for respiratory problems.

Yet Doctor Fitzsimmons maintains that it would be wrong to draw comparisons between the two systems because they are so different. "People need to go and experience the contrasts for themselves," he says. "That is the reason for the ARMX exchange."

Another reason for the ARMX exchange is the curiosity Russian physicians evinced about the American medical system. "Russian doctors are desperately hungry, not just for supplies, but for information," says Doctor Springer. "They don't understand our insurance system, family practice or primary care, but they have techniques they want to share with us." The Russian physicians are very well trained, according to Doctor Springer, although grounded in schools of thought and philosophy vastly different to the traditional US medical schools.

Doctors Springer and Fitzsimmons came away from Russia with great respect for the Russian people and a desire to help. "There is no doubt today (that Russians) want change," says Doctor Fitzsimmons. "They know they need help and they know America will help. We have technology, education, organizational skills and supplies to export. They are now open and receptive to our overtures."

Community coalitions sought

The two physicians have worked steadily to build community coalitions to support the ARMX Exchange. They have met with members of several community groups including representatives from MSU, MSMS, the Institute of International Health and local hospitals.

Through their trips Doctors Springer and Fitzsimmons have also developed working relationships with specialists in Russia. This has helped with the planning for two proposed sports medicine symposia; one to be held in East Lansing, October 1993, and the other the week prior to the Goodwill games in the summer of 1994 in St. Petersburg.

The focus on sports medicine will make the most of the well established contacts sports medicine already has within Russia, explains Doctor Fitzsimmons. Athletes, because of their traditionally privileged position in Russian society, have the easiest access to health care in Russia. "Without the contacts and connection of athletes, coaches and trainers, my ability to visit medical personnel would have been severely restricted," says Doctor Fitzsimmons. It was these people who helped Doctors Fitzsimmons and Springer arrange their visits to hospitals. The sports community knows how to work within the remnants of the highly structured, but failing system.

Like the points of light that initiated the ARMX, the future of the program looks bright. There are proposals for developing linkages with MSU's colleges of human and osteopathic medicine and for sharing medical technology and administrative techniques with Russian physicians.

"We are still in the preliminary stages," says Doctor Springer. The Russian medical community has many levels of need.

Helen Fordham is chief of community relations for MSMS.

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BY HELEN FORDHAM

"I would volunteer to climb any mountain anywhere in the world"



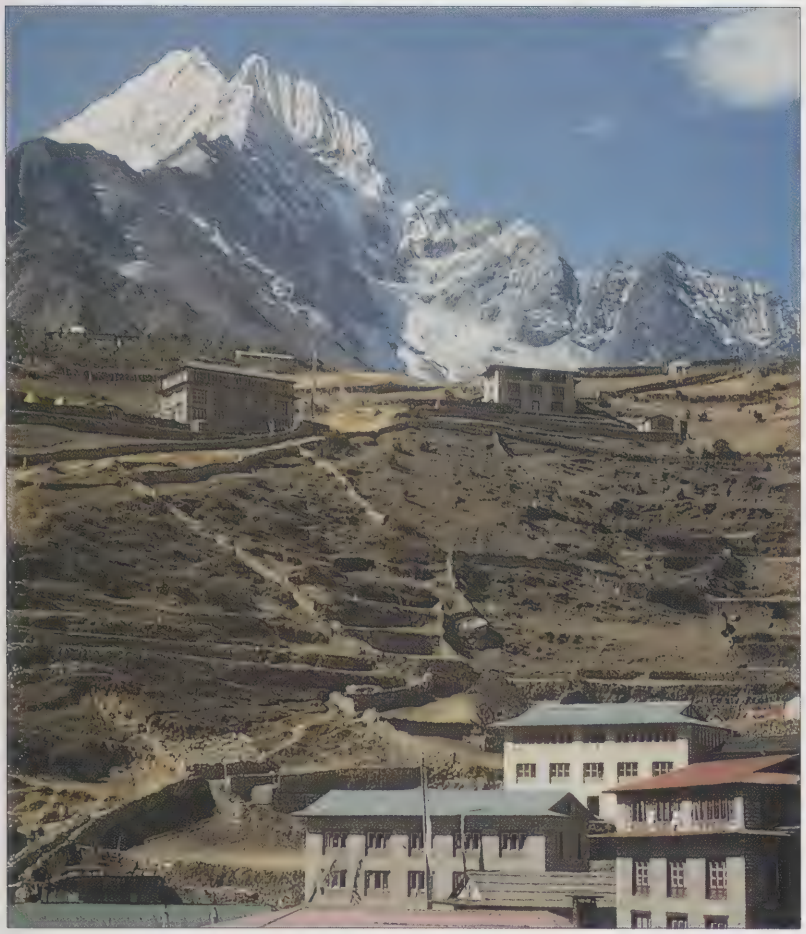
Reaching new heights again...and again...and again... In little more than three decades, this Grand Rapids physician has climbed more than 150 mountains on six continents

Top photo: Douglas Mack, MD, and a mountaineering companion look out over the Himilayan Mountains. Mt. Everest is the peak in the background at their feet.

Photo at left: The mountain climbers visited several Buddhist monasteries and temples, which are scattered throughout the foothills of the Himalayas. Shown here is a monk reading the prayer scripts.

Top photo, opposite page: The snow covered slopes of 21,679-foot Mt. Thamserku rises above the Sherpa Village, Namche, where Doctor Mack spent two days.

Bottom photo, opposite page: Doctor Mack holds a Butterworth Hospital Flag.





"We've got trouble," the sherpa guide said, as he peered down the steep slope below the treeline to the gaggle of climbers and bearers.

Hearing this, the expedition's physician, Douglas A. Mack, MD, MPH, was immediately on his feet and beside the guide. One of the Sherpas from below began to gesture frantically for the doctor to come quickly.

Scrambling over rocky outcrops, Doctor Mack ran two miles back to where Paul, one of the expedition's nine mountain climbers, lay on the ground. He was immobile, non-responsive and his head was beginning to swell ominously.

A Grand Rapids' physician and director of the Kent County Health Department, Doctor Mack has treated a few minor wounds and traumas in his 34 years of climbing mountains. This was the first time he had to deal with a potentially fatal cerebral edema.

"It's fairly rare, but it happens often enough that people know of it," explains Doctor Mack. "It strikes completely randomly and fitness has no relationship to its occurrence."

The young man's brain was swelling as a result of the high altitudes, placing pressure on his motor functions so he couldn't move. Realizing Paul could be dead within two hours, Doctor Mack wasted no time in hoisting his patient aloft and, with the help of several bearers, spent two gruelling days descending to 12,000 feet. "It was a real struggle," recalls Doctor Mack. "We had no means of carrying Paul except in our arms and the terrain was rugged."

At the lower level the swelling decreased and Paul began to recover. Doctor Mack was awarded the Nepal Rescue Association Cap for his quick thinking. The association is a corps of international volunteer physicians that staff a clinic in the Nepalese mountains.

Doctor Mack speaks modestly of the rescue. Conditions can be treacherous in high altitudes and it is important to be prepared. Incidents like Paul's are unusual, he says. Loss of weight and dehydrations are major concerns, he adds, but there is usually very little trauma. "People are cognizant and very aware of where they are."

After ensuring Paul's recovery, Doctor Mack continued his climb to the summits of Kalaphather, Goyko Rea and Imja Himmel in the Nepalese Mountains. He spent four weeks traversing these peaks at the foot of Mount Everest, reaching heights of 20,000 feet.

An avocation

Nepal was Doctor Mack's most recent climb and he considers it one of his most memorable. "The last one is always the best," he says with a smile. "The memories are most vivid." He thought the same back in 1960 when he conquered his first mountain, an 11,000-foot peak in South-

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ern California, and knew he was hooked. "I would volunteer to climb any mountain anywhere in the world," he says.

He has already climbed more than 150 mountains on six continents, ranging from the rather modest 7,313 feet of Australia's Mt. Kosciusko to the 22,831 feet of Mt. Aconcagua in Argentina. He has scaled Mt. Whitney, the tallest mountain on the US mainland, and he plans to climb the highest peak in each of the 50 states.

Doctor Mack says he would return to any of the mountains he has climbed. "They were all special in their own way," he explains. Yet he makes a point of mentioning the climb he made up Mt. Kilimanjaro in Tanzania where the expedition went from steaming jungle to snow during the four-mile climb. He also speaks fondly of the overwhelming beauty of Mt. Cook in New Zealand. Perhaps his most physically challenging climb was an ascent of the icy face of Mt. McKinley in Alaska, after he had been dropped by plane on a glacier 6,000 feet above sea level.

Climbing is a passion for Doctor Mack. He acknowledges that the physical challenge is a part of the attraction. "Those who go on these trips have to be physically fit," he explains.

You don't have to be a marathon runner but it certainly helps. Many of the climbers are athletes and Doctor Mack prepares himself for his climbs by working out every day with weights and an hour of running. He also runs marathons regularly, which he finds helps with the mental discipline required to climb mountains. In 1992 he ran three marathons, including one the day after he returned from Nepal. Not bad for a 57-year-old man.

Part of the physical challenge of mountain climbing is the constant presence of danger. Doctor Mack acknowledges the danger. "But I don't think of death," he explains, "because I've planned for all eventualities." He admitted that there are some things over which a climber has no control, like the weather. But if something ever did happen and he died, it would be while doing something he loved in a place he loved, he reasons.

Forces other than mere challenge propel Doctor Mack to climb mountains. "There is something about the mountains that is spiritual," he explains. "You become attuned to nature, you meld with it; you develop a keen awareness of your surroundings because there is nothing to distract you." The isolation and the overwhelming beauty of the mountains strips away all the facades that people surround themselves with in society; there is no routine and time becomes irrelevant. "In the mountains you are really you and you are you with the rest of the nature," he says. "Not enough people allow themselves to do this."

The ability to be himself is important to Doctor Mack, who can remember growing up as one of seven children in the flatlands of Ontario. "I used to look across the St. Lawrence river to the Adirondacks Mountains and envision climbing them. Even then I was trying to find an environment in which to be myself."

His role in public health

As director of public health and chief medical examiner for Kent County since 1977, Doctor Mack sees his mountain climbing avocation as a perfect complement for his profession. In an office bedecked with pictures of the mountains he has climbed, Doctor Mack admits that the new perspectives he acquires while interacting with other cultures has helped him successfully build coalitions and take new approaches to community health problems in Kent County.

"A lot of our projects have received awards," says Doctor Mack, who counts on a staff of 300 and presides over an annual budget of $16 million to implement programs ranging from AIDS education to no smoking policies. He praises the work of his colleagues in helping to create partnerships to address health issues and speaks proudly of the most recent project, which saved the Grand Rapids Cherry Street Clinic from certain closure.

Like mountain climbing, Doctor Mack moved from family practice into public health because of the challenge. "I wanted to have an impact on a community broader than my practice," he explains.

He has a vision for public health and believes preventive medicine is a key to solving many of the current communities' health problems. "The impact of public health policies should be to work ourselves out of a job," he explains. In encouraging the public to develop healthy lifestyles, Doctor Mack leads by example. "I don't drink, or smoke and I work out," he says. "If you espouse it you have got to live it."

Doctor Mack has been recognized for his contributions to public health. He is the only member of the Michigan Health Officers Association to receive its Distinguished Service Award twice. He also is the first state public health official to be appointed to the Board of Medicine. Just recently, he was named a 1993 national scholar by the Centers for Disease Control in Atlanta.

Doctor Mack brings to his position all the commitment, tenacity and discipline he applies to mountain climbing. He believes that the patience he has been forced to acquire and the open communication that accompanies mountain climbing have helped to make him more successful. And just like his devotion to mountain climbing, he feels passionately about his job. "I wouldn't change this job for anything in the world," he says. Doctor Mack hasn't given up on the mountains either. He is currently making plans for his next climbing expedition - to Antarctica.

Helen Fordham is chief of community relations for MSMS.

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MSMS

HEALTH EDUCATION FOUNDATION

Physician care reaches into the community

By Claudia Skutar

Some Michigan physicians have found a way to extend their practices out of the office and into the community. During 1992-1993, these doctors will go beyond exams and operating tables to monitor the health of their patients.

They'll help children to learn more about vegetables good for their health. They'll help middle school and high school students learn more about health careers. They'll give a boost to volunteer respite services in Michigan communities. They'll help make CPR equipment and training available to middle and high school students, and adults in the community. How is that possible today, when physicians already spend long hours between office and hospital to care for their patients? The answer is the MSMS Health Education Foundation (HEF). Begun in 1946, the foundation each year pools money contributed by doctors statewide, then provides grants to selected applicants to help educate people about good health. "HEF helps doctors review community needs and find out how they can help," says MSMS President Thomas C. Payne, MD, East Lansing.

For instance, through HEF, Michigan doctors are sponsoring development of an educational 4-H Children's Garden on the campus of Michigan State University in East Lansing. The first of its kind on any U.S. college campus, the garden will contain a variety of themes to aid children in learning about plants and their uses. HEF provided a grant for one part of the garden that will be known as "Health to Better Living." In this section, children will be able to learn about vegetables cited by the U.S. Department of Agriculture as most nutritious.

Altruistic causes a primary focus

Endeavors such as this are a primary focus of HEF, according to its president, Robert E. Paxton, MD, Fremont. "MSMS has a mandate in its constitution and bylaws requiring a concern for altruistic causes."

In fact, as MSMS activities have become more socioeconomic, HEF was developed as a separate arm so that MSMS could continue to fulfill this mandate and maintain its altruistic activity, says Doctor Paxton.

That activity includes HEF financial aid to other community projects. The Respite Volunteer Association, an umbrella organization for local respite care groups around Michigan, will use an HEF grant this year to provide money to Genesee and Jackson County respite care efforts. These groups provide a volunteer in the home to help care for a dependent adult, allowing the primary caregiver a temporary break, or respite, from the care.

It's the first time the association has applied to HEF for a grant, says Ellen McKay, coordinator of Aging Ministry at the Catholic Diocese of Lansing, which oversees the association. "Physicians are key to helping," she says, and not just through HEF funding. "Physicians can provide information on local respite care if they think a patient's family caregiver would benefit from this." McKay says a future association project being planned is development of special oversize physician prescription pads. They'll be distributed to doctors' offices for use in informing patients about respite care.

While doctors have a great deal of knowledge and credibility with their patients, sometimes they are unable to make use of that knowledge when an emergency strikes far from their homes, offices or hospitals.

Webberville, Michigan is 25 miles from the nearest medical facility. To help save lives in a respiratory or cardiac emergency, the Webberville school system continuously has expanded its CPR program to train as many students and community members as possible in adult, child and infant CPR techniques. That program began in 1984 in a ninth grade health class. As it has expanded to include students in other grades, adults and local fire department workers, more CPR equipment has been necessary. HEF funds will help the school system obtain more equipment this year.

Program coordinator Nola Kingsley said a grant was sought from HEF because "HEF goals most closely matched our goals for health education." Purchase of more CPR equipment was important to continuing the scope of Webberville's program since, "we couldn't afford to continue renting equipment," Kingsley explains.

"This is an excellent example of how MSMS is trying to respond to community needs," pointed out Doctor Payne. "The Webberville school system is getting immense use out of this equipment."

HEF will help another organization target a different kind of health education in the schools. With the aid of an HEF grant, the Michigan Health Council is developing a

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health careers manual for middle and high school students around the state. The manual, another first-of-its-kind Michigan project, will help guide students on the many choices and opportunities in health careers.

"We need to increase the health workforce, and the only way to do this is to get a book like this out," Michigan Health Council President Anne Rosewarne says.

The manual will be sent to all middle and high school counselors in September. Annual updates are planned, since the book contains job outlook and salary information. "With another grant, we may set up a health careers hotline," says Rosewarne.

Physician contributions urged

Physicians can help fund projects like these through contributions to HEF. The foundation sent letters to all MSMS members last fall outlining how they can make HEF contributions and urging them to do so. A similar letter is planned for April.

Many physicians aren't aware that contributions also can take the form of participation in the annual HEF weekend family outing, which was held for the first time last year. While that outing was a success, HEF hopes for more physician participation this year. The foundation is urging physicians to attend this year's outing August 13-15 at Crystal Mountain Resort. Physicians and their families can relax and enjoy time together with activities like golf, charter fishing, tennis, hiking, and children's activities.

Traditional contributions, including bequests, cash, stocks, bonds, life insurance and property also are accepted by the foundation.

"HEF needs the involvement of the MSMS leadership and membership to make it successful," says Doctor Paxton.

For more information on how to make a contribution, contact HEF Executive Secretary Dawn Reha at (517) 336-7589.

Claudia Skutar is communication's specialist for MSMS.

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- Stimulate, support and/or initiate lay or professional education, research programs, and projects in the field of health.
- Encourage the advancement of healthy lifestyles, the prevention, diagnosis or cure of disease, and the care of the sick and the dying.
- Provide a vehicle for the Michigan State Medical Society to foster humanitarian public service in health education and research, and to provide support for physicians who suffer impairment.
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Clinical Laboratory Improvement Amendments (CLIA) of 1988

Here are answers to your most frequently asked questions

By Tom Wolff

MSMS is undertaking a new regulatory compliance activity to educate physicians concerning state and federal laws which affect their medical practice. The initial focus of this initiative is on the Clinical Laboratory Improvement Amendments (CLIA) of 1988 and the Americans with Disabilities Act (ADA). As chief of State Government Affairs for MSMS and a licensed attorney, I am available to answer physicians' questions concerning key state and federal laws and regulations.

MSMS held three CLIA seminars in February, and six other seminars are scheduled for April and May. The CLIA seminar schedule is as follows:

April 19	Flint	5:00 pm - 9:00 pm
April 20	Detroit	1:00 pm - 5:00 pm
April 21	Kalamazoo	1:00 pm - 5:00 pm
May 11	Grand Rapids	1:00 pm - 5:00 pm
May 12	Traverse City	1:00 pm - 5:00 pm
May 13	Marquette	5:00 pm - 9:00 pm

For additional information concerning these seminars, please call Lori Randall at MSMS (517) 336-5728.

I am also available to make presentations to county medical societies, hospitals, medical staffs, and other groups of physicians, has developed the following article which provides answers to many common physician questions concerning the CLIA regulations.

Q To which laboratories does CLIA apply?

A CLIA applies to all testing of human specimens for the diagnosis, prevention, or treatment of disease or impairment, or for the assessment of the health of human beings. Thus, CLIA covers virtually every laboratory testing site, including physician office laboratories. CLIA applies whether or not the laboratory bills for the service. However, if a facility only collects specimens and then transports them to a laboratory for testing, the specimen collection facility would not be covered by CLIA.

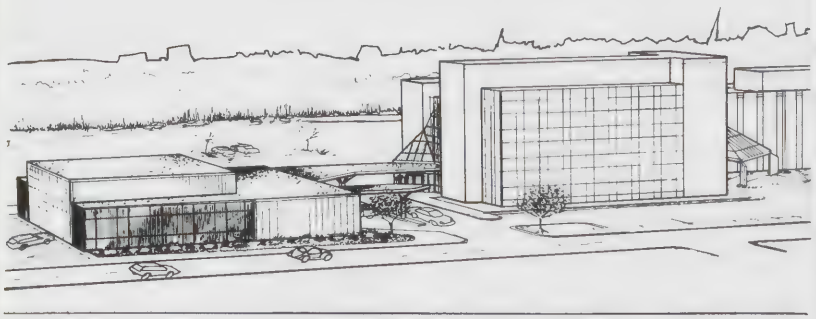
Q What is the deadline for obtaining a CLIA identification number?

A The deadline for obtaining a CLIA identification number without having Medicare deny claims for laboratory services has been extended from December 1, 1992, to March 1, 1993. Before denying payment, the Medicare carrier will notify the physician that federal records show that the physician does not have a CLIA number on file. The physician will then have three options:

- contact the Michigan Department of Public Health to request the necessary application forms to become a CLIA-registered laboratory;
- notify the Medicare carrier that the records are in error by providing the carrier with his or her CLIA identification number; or
- stop performing laboratory tests.

Continued on following page

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■ ■ ■

For confidential consideration, send cover letter and CV to
Stan Gruhn, M.D., Riverview Clinic
P.O. Box 551, Janesville, WI 53547-0551

Continued from page 45

Q How does a physician obtain an identification number?

A Physicians must complete application forms HCFA-114 and HCFA-116 and return them to HCFA. HCFA will then send a fee remittance coupon that includes the physician's CLIA identification number, the amount due for the certificate and, if applicable, the compliance (biennial inspection) fee. After HCFA receives the amount due for the certificate, it will issue the appropriate certificate (certificate of waiver, certificate for physician-performed microscopy procedures or registration certificate).

Q Where can physicians get forms HCFA-114 and HCFA-116?

A Physicians should call the Michigan Department of Public Health at (517) 335-8151.

Q What are the penalties for failing to obtain an identification number?

A In addition to having Medicare and Medicaid payments denied, physicians will be subject to civil and criminal penalties if they fail to obtain an identification number.

Q If a physician's laboratory is already accredited by the Commission on Laboratory Accreditation (COLA) or another private accrediting entity, is the physician still required to obtain an identification number?

A Yes. The physician is still required to obtain an identification number. HHS will approve accreditation programs that meet CLIA standards. If COLA or the other entity is approved by HCFA, the laboratory can then apply for a certificate of accreditation.

Q How does a physician know whether he or she qualifies for a certificate for physician-performed microscopy procedures?

A A physician may qualify for a certificate for physician-performed microscopy procedures if he or she conducts only one or more of the following physician-performed microscopy procedures or only such procedures and waived tests:

- wet mounts, including preparations of vaginal, cervical or skin specimens;
- all potassium hydroxide (KOH) preparations;
- pinworm examinations;
- fern tests;
- post-coital direct, qualitative examinations of vaginal or cervical mucous; and
- urine sediment examinations.

Q How does a physician know whether he or she qualifies for a certificate of waiver?

A A certificate of waiver is issued to laboratories that perform *only* waived tests. The following are the waived tests:

- fecal occult blood
- ovulation tests - visual color comparison tests for human luteinizing hormone
- urine pregnancy tests - visual color comparison tests
- erythrocyte sedimentation rate (non-automated)
- hemoglobin copper sulphate (non-automated)
- blood glucose, by glucose monitoring devices cleared by the FDA specifically for home use.
- spun microhematocrit
- hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout.
- dipstick or tablet reagent urinalysis (non-automated) for: bilirubin; glucose; hemoglobin; ketone; leukocytes; nitrate; protein; Ph; urobilinogen; and specific gravity.

Q If a physician performs both waived and non-waived tests, will the physician receive both a certificate of waiver and a registration certificate?

A No. A physician will receive only a registration certificate. Certification for the highest level of testing performed is the only certificate required.

Q Can one individual perform the functions of laboratory director, clinical consultant, technical consultant, and testing personnel?

A If an individual meets the qualifications specified, he or she can perform all four functions.

Tom Wolff is chief of state government affairs for MSMS.

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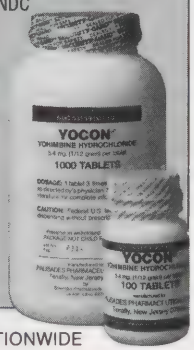
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

March

9, 16, 23, 30, Defining Emotional Health in the Light of Ancient Wisdom. Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 10 hours Category I Credit.

10-12, PET and SPECT Brain Imaging in Clinical Practice and Research. Location: Thomas B. Turner Building, Johns Hopkins Medical Institutions, Baltimore, Maryland. **Sponsor:** Johns Hopkins University School of Medicine. **Contact:** Patty Campbell, Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Education, Turner Building, 720 Rutland Avenue, Baltimore, Maryland 21205, (410) 955-6046. **Approved for:** 18 hours Category I Credit.

12, Physician Image: How Do You Communicate Caring. Location: Radisson on the Lake, Ypsilanti, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Office of Physician Education, (517) 336-5784. **Approved for:** 3.5 hours Category I Credit.

16-20, Family Practice 1993, Seventeenth Annual Spring Review Course. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Michigan Academy of Family Physicians. **Contact:** Robin Rice, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 33 hours Category I Credit.

18-19, Colposcopy for the Primary Care Physician. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsors:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 12 hours Category I Credit.

20, Mid Michigan Eye Care Center. Location: Chelsea Hospital, Chelsea, Michigan. **Sponsor:** Mid Michigan Eye Care Center. **Contact:** Janet Lapp, COT, (517) 782-9436. Approved for: 3 hours Category I Credit.

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CATEGORY I COURSES

20-21, Stress EKG. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland MI 48640, 1-800-462-2492. **Approved for:** 11.5 hours Category I Credit.

25-26, Colonoscopy/Common Naorectal Disorders/Hemorrhoids. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland MI 48640, 1-800-462-2492. **Approved for:** 12 hours Category I Credit.

27, Advanced Trauma Life Support, Student Reverification Course. Location: Towlsey Center, University of Michigan Medical School, Ann Arbor, Michigan. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons and University of Michigan Medical School. **Contact:** Steve Cruise, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. Approved for: 3 hours Category I Credit.

27, Fourth Annual Symposium on Medical Complications of Pregnancy: "Medical Emergencies in Pregnancy." Location: William Beaumont Hospital, Royal Oak, Michigan. **Sponsor:** William Beaumont Hospital. **Contact:** Liz Kretschmann, Office of Continuing Medical Education, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073-6769, (313) 551-0429. **Approved for:** 4 hours Category I Credit.

27-28, EDG (Gastroscopy). Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 12 hours Category I Credit.

April

1-2, Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Marie McKnight, Registrar, Office of Continuing Medical Education, Towsley Center, Box 1157, University of Michigan Medical School, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 14 hours Category I Credit.

13, Effective Compassion for the Incurably Ill. Location: Fetzer Center, Kalamazoo, Michigan. **Sponsor:** Michigan State Medical Society, Committee on Bioethics. **Contact:** Helen Fordham, MSMS Committee on Bioethics, (517) 336-5786. **Approved for:** 6 hours Category I Credit.

14-16, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michi-

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Continued from page 51

gan Medical School, Department of Radiology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400.

16-17, Sclerotherapy/Peripheral Vascular Evaluation. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 11.5 hours of Category I Credit.

19, 20, 21, How to Comply with CLIA Regulations. Location: April 19, Holiday Inn, Flint, Michigan. April 20, Wayne County Medical Society, Detroit, Michigan. April 21, Fetzer Center, Kalamazoo, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Tom Wolff, MSMS Regulatory Ombudsman, (517) 336-5740. **Approved for:** 3.5 hours Category I Credit.

20, Advanced Pain and Symptom Management. Location: Holiday Inn Crowne Plaza, Grand Rapids, Michigan. **Sponsor:** Michigan Hospice Organization. **Contact:** Sue Wierengo, (616) 722-2257. **Approved for:** 3.5 hours Category I Credit.

22 & 23, Medicolegal Investigations of Death. Location: Holiday Inn Fairlane, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Pathology. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 14 hours Category I Credit.

23-24, Contraceptive Update/No Scalpel Vasectomy. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, Mi 48640, 1-800-462-2492. **Approved for:** 15 hours Category I Credit.

23-24, Advanced Trauma Life Support, Instructor Course. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons and University of Michigan Medical School. **Contact:** Steve Cruise, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

25, Leep/Letz/Loop. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 5.75 hours Category I Credit.

26-30, Advances in Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of

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Michigan Medical School, Department of Internal Medicine. **Contact:** Marie McKnight, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 33 hours Category I Credit.

May

11, 12, 13, How To Comply with CLIA Regulations. Location: May 11, Holiday Inn Crown Plaza, Grand Rapids, Michigan. May 12, Grand Traverse Resort, Traverse City, Michigan. May 13, Holiday Inn, Marquette, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Tom Wolff, MSMS Regulatory Ombudsman, (517) 336-5740. **Approved for:** 3.5 hours Category I Credit.

13, Flexible Sigmoidoscopy/Hemorrhoids. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, (800) 462-2492. **Approved for:** 7.5 hours of Category I Credit.

13-14, Vestibular Rehabilitation. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

14-15, EGD (Gastroscopy). Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI, 48640, (800) 462-2492. **Approved for:** 12 hours Category I Credit.

17-22, All Michigan OB/GYN Review Course. Location: Radisson On The Lake, Ypsilanti, Michigan. **Sponsor:** Wayne State University School of Medicine, Wayne State University, University of Michigan and Michigan State University. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 37 hours Category I Credit.

June

1, 2, Diagnosis and Management of Breast Cancer. Location: June 1, Novi Hilton, Novi, Michigan. June 2, WMU Regional Center, Grand Rapids, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

3-4, Current Topics in Blood Banking 20th Annual Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medial School,

Continued on following page

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P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

4-5, Phonosurgery - Indications and Techniques. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

7-10, 6th Annual Summer Conference on Aging. Location: Novi Hilton, Novi, Michigan. **Sponsor:** Wayne State University School of Medicine, Institute of Gerontology. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180.

21-25, 29th Annual, Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Marie McNight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400.

July

11-13, 7th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort Village, Grand Traverse Resort, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 15 hours Category I Credit.

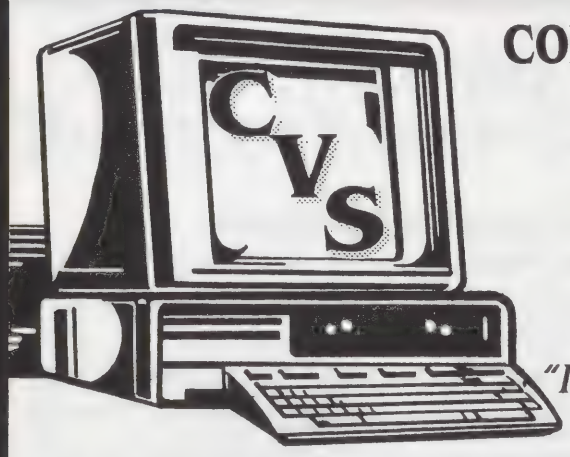
29-30, 73rd Annual Collier Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, Michigan. **Sponsor:** Munson Medical Center and Medical Staff. **Contact:** Elaine Gaines, Medical Education, Munson Medical Center, 1105 Sixth St., Traverse City, MI 49684-2386, (616) 935-6546.

August

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. **Contact:** Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 60 hours Category I Credit.

September

15, Diagnosis and Management of Myocardial Infarction. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan State



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Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

22, 23, Diagnosis and Management of Myocardial Infarction. Location: September 22, Novi Hilton, Novi, Michigan. September 23, WMU Regional Center, Grand Rapids, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

October

5, 6, 7, Providing Outstanding Patient Service. Location: October 5, Treasure Island, Saginaw, Michigan. October 6, Novi Hilton, Novi, Michigan. October 7, MSMS Headquarters, East Lansing, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Office of Physician Education, (517) 336-5784. **Approved for:** 6.5 hours Category I Credit.

November

3, 4, Diagnosis and Management of Colon & Prostate Cancer. Location: November 3, WMU Regional Center, Grand Rapids, Michigan. November 4, Novi Hilton, Novi, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

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MEETINGS

MSMS Meetings

March

12, MSMS Practice Management Seminar, "Improving Physician Image: How Do You Communicate Caring?" and "Reclaiming the Joy of Medicine." Radisson on the Lake, Ypsilanti, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

12-13, MSMS Joint Section Annual Meeting, Radisson on the Lake, Ypsilanti MI. Contact: Judy Marr, MSMS Manager, Communications and Professional Relations, (517) 337-1351.

16, 17, 18, MSMS Supervisory Skills Series - Part I "Master the Principles of Office Supervision." March 16, Wayne County Medical Society, Detroit, MI. March 17, Holiday Inn, Flint, MI. March 18, Fetzer Center, Kalamazoo, MI. Contact: The Office of Physician Education, (517) 336-5784.

16, 18, 23, MSMS/MPMLC Fundamentals of Risk Management. March 16, WMU Regional Center, Grand Rapids, MI. March 18, Wayne County Medical Society, Detroit, MI. March 23, Holiday Inn South, Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

18-19, MSMS Practice Management Seminar, "Medical Biller Training Series (Blue Cross/Blue Shield)," Novi Hilton, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

23, MSMS Government Affairs Day, Lansing Civic Arena, Lansing, MI. Contact: Sandra Bitonti, Manager, MSMS Department of Government Affairs, (517) 337-1351.

24, MSMS Board Meeting, Michigan State Medical Society, East Lansing, MI. Contact: William Madigan, MSMS Executive Director, (517) 336-5734

24, MSMS/MPMLC Risk Management: Closed Claim Reviews (Obstetrics/Gynecology), Holiday Inn South, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

24-25, MSMS Maternal and Perinatal Health Conference, Holiday Inn South, Lansing, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

25, 30, 31, MSMS Practice Management Seminar, "Coding Clinics for Specialties." March 25, Holiday Inn South, Lansing, MI (OB/GYN). March 30, Hotel Baronette, Novi, MI (Anesthesiology/General Surgery). March 31, Treasure Island, Saginaw, MI (Anesthesiology/General Surgery). Contact: MSMS Office of Physician Education, (517) 336-5784.

31, MSMS/MPMLC Risk Management: Closed Claim Reviews (Psychiatry), Sylvan Resort, Gaylord, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

Continued on page 58

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MICHIGAN STATE MEDICAL SOCIETY
INSURANCE PROGRAMS

MEETINGS

Continued from page 56

April

1, MSMS/MHA Enhancing Hospital/Physician Relations, Sheraton Oaks, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

1-2, MSMS/Practice Management Seminar, Orientation to the Medical Office, WMU Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

6, 7, 8, MSMS Practice Management Seminar, "Electronic Billing: Do You Know All you Need to Know?" April 6, Grand Traverse Resort, Traverse City, MI. April 7, Troy Marriott, Troy, MI. April 8, WMU Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

7, 8, 14, 15, MSMS/MPMLC Risk Management: Closed Claim Reviews (Psychiatry). April 7, Treasure Island, Saginaw, MI. April 8, Novi Hilton, Novi, MI. April 14, WMU Regional Center, Grand Rapids, MI. April 15, MSMS Headquarters, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

8, MSMS CME Accreditation Conference, Michigan Athletic Club, East Lansing, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education,(517) 336-5727.

12-13, MSMS Practice Management Seminar, "Medical Biller Training Series (Medicare)," Novi Hilton, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

13, MSMS Program, "Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide," Fetzer Center, Kalamazoo, MI. Contact: Helen Fordham, MSMS Communications, (517) 336-5786.

15, MSMS Opportunities 1993: An Array of Medical Practice Opportunities for Michigan Physicians, Detroit, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

15, MSMS Professional Well-Being Workshop, Holiday Inn, Flint, MI. Contact: Sherry Fent, MSMS Office of Physician Education, (517) 336-5784.

19, 20, 21, MSMS Practice Management Seminar, "How to Comply with CLIA Regulations." April 19, Holiday Inn, Flint MI. April 20, Wayne County Medical Society, Detroit, MI. April 21, Fetzer Center, Kalamazoo, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

20, 21, 22, MSMS Supervisory Skills Series - Part II (How to Deal With Difficult People and Situations). April 20, Holiday Inn, Flint, MI. April 21, Michigan Athletic Club, East Lansing, MI. April 22, Hotel Baronette, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

20, 21, 22, 27, MSMS/MPMLC Risk Management: Closed Claim Reviews (Pathology). April 20, Sylvan Resort, Gaylord, MI. April 21, Treasure Island, Saginaw, MI. April 22, Novi Hilton, Novi, MI. April 27, MSMS Headquarters, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

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- **Adult and Pediatric LAMP systems are available**

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MEETINGS

27, 28, MSMS Coding Clinics for Specialties. April 27, WMU Regional Center, Grand Rapids (Radiology/Primary Care). April 28, Holiday Inn, Flint, MI (Radiology/Primary Care). Contact: MSMS Office of Physician Education, (517) 336-5784.

29, MSMS Future Vision: Physicians in the Year 2002, Ritz Carlton, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

30, MSMS Board Meeting, Michigan State Medical Society, East Lansing, MI. Contact: William Madigan, MSMS Executive Director, (517) 336-5784.

30-May 3, MSMS House of Delegates, Ritz Carlton, Dearborn, MI. Contact: Donna Farougi, Coordinator, Special Programs, (517) 336-5735.

May

2, MSMS Board Meeting, Michigan State Medical Society, East Lansing, MI. Contact: William Madigan, MSMS Executive Director, (517) 336-5734.

July

14-18, MSMS Midsummer Board Meeting, Shanty Creek, Bellaire, MI. William Madigan, MSMS Executive Director, (517) 336-5734.

November

9-11, MSMS Annual Scientific Meeting, Westin Hotel, Detroit, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

Michigan Specialty Society Meetings

August

14-20, The Twelfth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine. Contact: Society of Magnetic Resonance in Medicine, Inc., (510) 841-1899.

AMA Meetings

June

10-17, AMA House of Delegates, Chicago, IL. Contact: Judy Marr, MSMS Manager, Department of Communications and Professional Relations, (517) 337-1351.

Other Meetings

March

7-14, Midwest Doctors Medical Seminars, Snowmass Village, Colorado. Contact: Richard Campau, Michigan State Medical Society, (517) 337-1351.

8-13, Thirteenth Annual Mammoth Mountain Emergency Medicine Ski Conference. Contact: Mark Song, MD (714) 552-0831.

18-20, Spring Break for CME, PGA National Resort & Spa, Palm Beach Gardens, Florida. Contact: Karen Barnum, Meeting Coordinator, Florida Medical Association, (904) 356-1571.

29-31, Fiberoptics Workshops for the Difficult Airway, Red Lion's La Posada Resort, Scottsdale, Arizona. Contact: Marie McKnight, Registrar, Ann Arbor, MI (313) 936-9800.



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Continued from page 61

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PRESIDENT'S PAGE

Now is the time for medical liability reform

By Thomas C. Payne, MD

If Michigan physicians, hospitals and patients ever have had a chance to see the benefits of meaningful medical liability reform, that time is now. But it won't happen without you.



It seems like MSMS and the 70-member Michigan Medical Liability Reform Coalition have been educating legislators, the media and the public about the need for medical liability reform for years. And, in fact, that is true.

Happily, our message is finally getting across. People are seeing the negative effects of our continuing medical liability crisis in every community in Michigan. Physicians are leaving. We can't recruit new physicians. Older physicians are retiring early. Access to care is threatened, not only access to specialists such as OBs, neurosurgeons and orthopedic surgeons, but to primary care physicians, as well.

We have made a difference

The Michigan Medical Liability Reform Coalition used every means possible to raise it as an issue in last fall's elections. We believe we made a difference.

In this new session, the Michigan Legislature has more proponents of medical liability reform. With the 55-55 split between Democrats and Republicans in the House, and with the shared committee chairs and the "stereo" speakers, we believe our bill will finally get a fair hearing in the House. When the arguments are weighed, we are confident the House and the Senate will report out a bill that Governor John Engler can proudly sign for the people of Michigan.

The going will be tough

But it's not going to be easy. The window of opportunity is open, but we have to put up a ladder and carry 56 state representatives through it as the trial lawyers chew on our legs.

At the Senate Judiciary Committee hearings in February, the Michigan Trial Lawyers Association continued to obfuscate the issue and use every trick in their little black briefcases to derail the bill or weaken it. To be honest, they made some headway.

So, if we are to be successful in the House, we will have to redouble our efforts. I know this seems like deja vu all over again. Didn't we just go through this? Didn't we just get done calling and writing our state representatives urging them to support medical liability reform?

The answer, obviously, is yes. But just as the price of freedom is eternal vigilance, so is the price of getting a meaningful medical liability reform bill through the Legislature.

Contact your legislators

Call your state representative today. Write to your state representative today. Simply tell them that you want their vote in favor of the medical liability reform bill.

The House has 27 freshman legislators and for each of them we have set up a meeting in their own district to discuss medical liability reform with local physicians and hospital people. If you would like to attend in your area, call Greg Aronin at MSMS for details at 517-336-5739. The Coalition also has produced a new patient education brochure packed with medical liability data. For 50 free copies, call Linda Beck at MSMS at 517-336-5783. Every one of us must make an effort if we are going to get this bill passed, and without it being watered down.

As hopeful as we are for success, we still have a tremendous uphill battle. But with physicians, hospitals, patients and members of the Coalition united behind reform, we've never had a better chance to improve the medical liability climate in Michigan.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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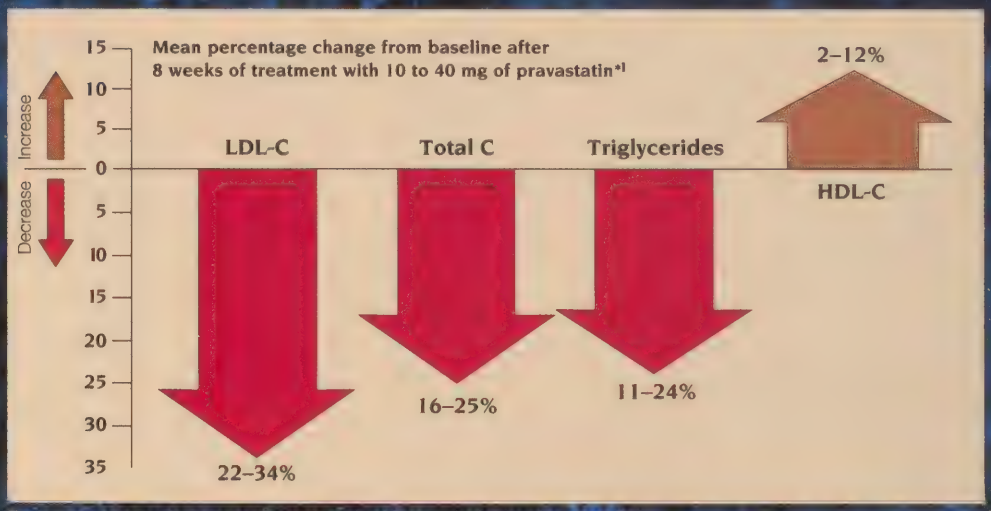
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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol* 1991;14:146-151.

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APRIL 1993
VOL. 92, NO. 4

Award-Winning Journal of the Michigan State Medical Society

Cover Story

POs & PHOs
The Beginning of a New Era in Medicine

Alternatives to Assisted Suicide

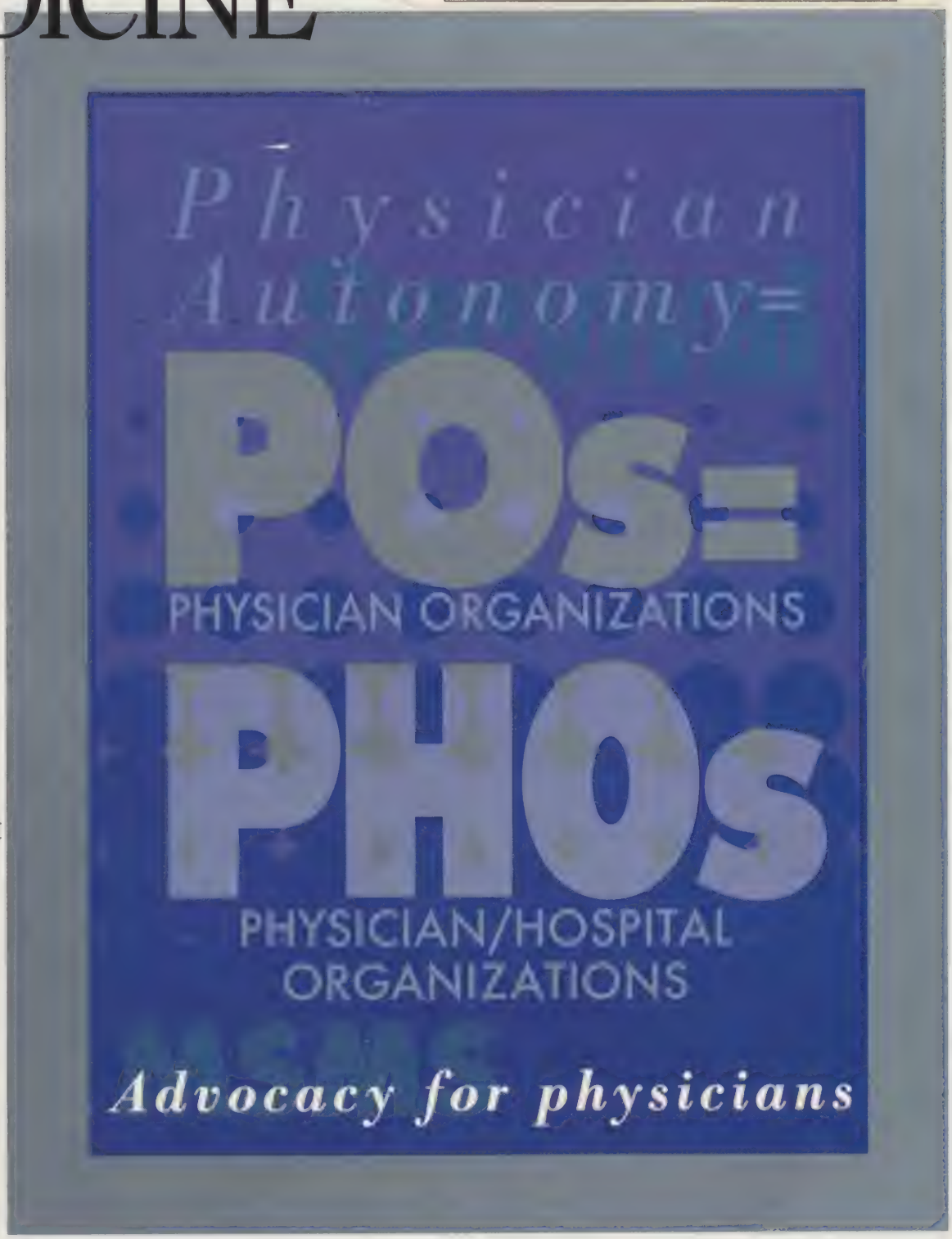
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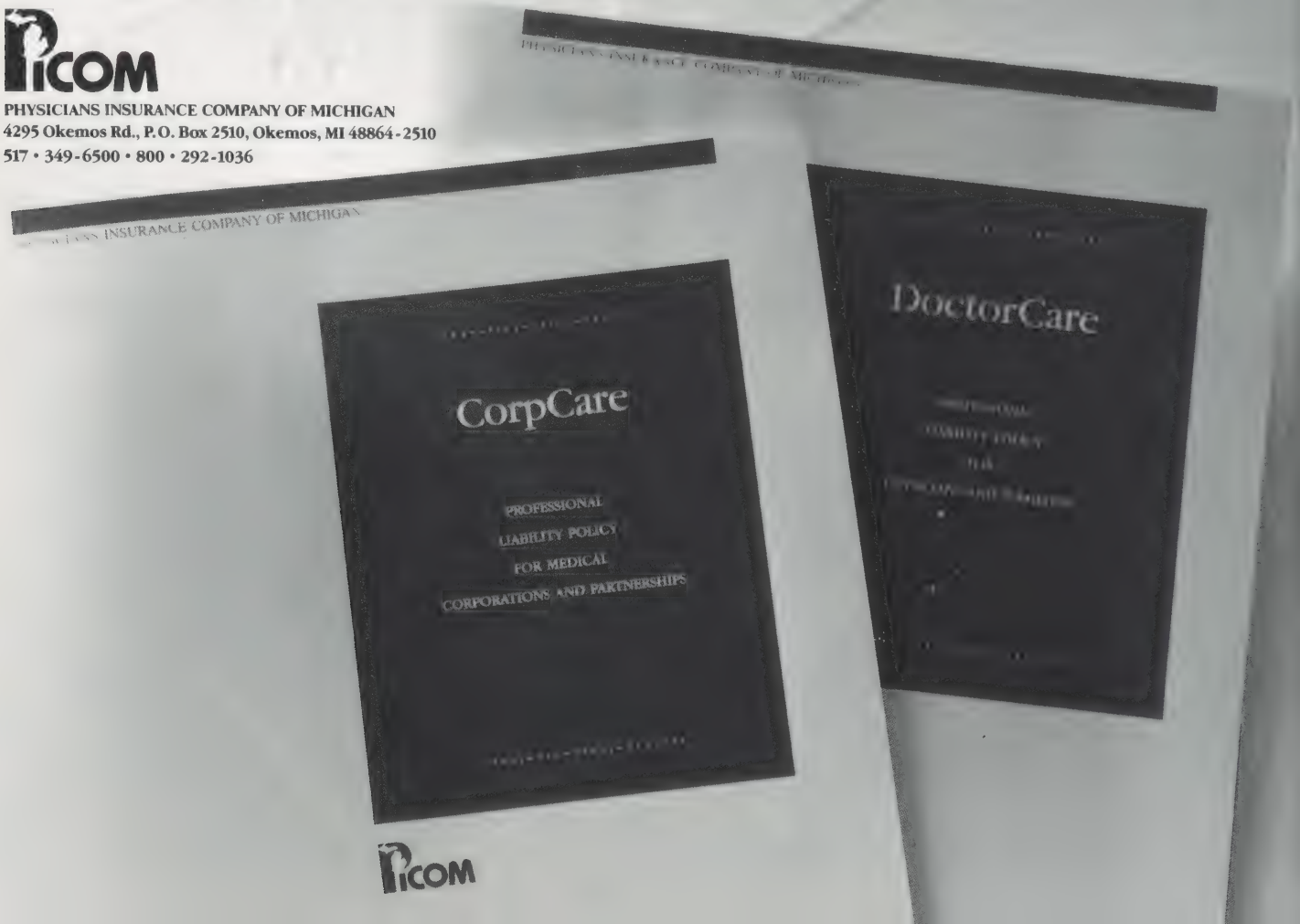
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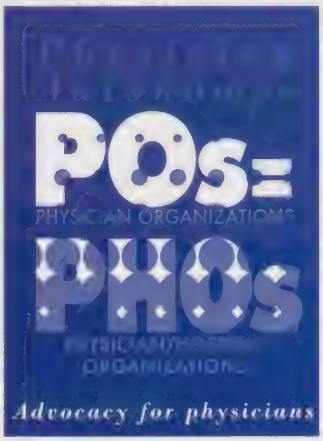
MICHIGAN MEDICINE

APRIL 1993 VOLUME 92, NO. 4

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

Physicians, hospitals, and managed competition signal the beginning of a new era in medicine. To help physicians better understand what lies ahead, this month's cover story includes: an introductory report from MSMS Executive Director William E. Madigan; a report on some of the new MSMS services that are being introduced in an attempt to "level the playing field" for physicians; an article by attorney and health policy consultant Tom Gorey which examines several models of "integrated health care delivery," including the PHO (physician hospital organizations) model; and highlights of an AMA report which describes managed competition and identifies some concerns for physicians.



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In next month's issue:
Results of MD Data Research Project

Cover Design: *By Stephen M. Amor, Abbott Press, Inc.*

Breast of chicken



3-oz. cooked serving of chicken breast

Best of pork



3-oz. cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

Compare pork with chicken[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz, cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.[1] According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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Betty J. McNerney

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranteed by MSMS.

Michigan Medicine (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published once each month, 12 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $100.00 (includes weekly *Medigram* newsletter); single copies, $3.00: Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news and exchanges should be addressed to Betty McNerney, advertising to Pat Horan, and address changes to Kathy Hagen, Michigan State Medical Society, P.O. Box 950, East Lansing, Michigan 48826-0950. Phone 517-337-1351.

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MSMS LEGAL BRIEFS



By Richard D. Weber

Update on Pension Plan Protection

Editor's note: Michigan Medicine is pleased to introduce this new monthly column which addresses legal issues of concern to Michigan physicians. This and all future columns will feature information provided by MSMS legal counsel Richard D. Weber of Kerr, Russell and Weber, Detroit. If you have a legal question you would like answered in this column, jot it down and send it to Betty McNerney at MSMS.

Last June, the United States Supreme Court held in *Patterson vs. Shumate,* 112 S. Ct. 2242 (1992) that ERISA-qualified pension plan assets are protected from creditor claims in bankruptcy. ERISA requires that qualified plans contain a non-alienation provision and the Supreme Court held that the Bankruptcy Code provides that a restriction on the transfer of assets which is enforceable under applicable nonbankruptcy law is enforceable in bankruptcy proceedings. The decision resolved the conflict among the Federal Circuit Courts of Appeals, some of which had held that the ERISA anti-alienation provision did not protect retirement plan assets from bankruptcy.

Although this Supreme Court decision appeared to close the door on creditor claims against qualified retirement plans, there was some discomfort on behalf of physicians and small employer plans. In *Patterson,* the debtor was an executive of a company with multiple participants. The debtor was not a trustee and had no discretion or control over the plan assets, other than as a beneficiary. Would the rule enunciated by the Supreme Court apply to a physician acting as the trustee and sole beneficiary of a plan within a small professional corporation? The United States Supreme Court has answered in the affirmative.

In October, 1992, the Supreme Court decided *Reed vs. Drummond,* 113 S. Ct. 314 (1992). Debtor Reed, a physician and the sole shareholder of his professional corporation, was the trustee and sole beneficiary of its pension plan. In 1988, Doctor Reed filed a voluntary petition under Chapter 7 of the Bankruptcy Code. He claimed his pension plan, worth approximately $800,000, as an exemption from his bankruptcy estate. The bankruptcy court denied Doctor Reed's claimed exemption and the federal district court affirmed. The Ninth Circuit Court of Appeals affirmed the district court's ruling and held that Doctor Reed's retirement plan was not exempt from creditor claims in bankruptcy. The United States Supreme Court granted Doctor Reed's petition for a writ of

Continued on following page

General Internal Medicine

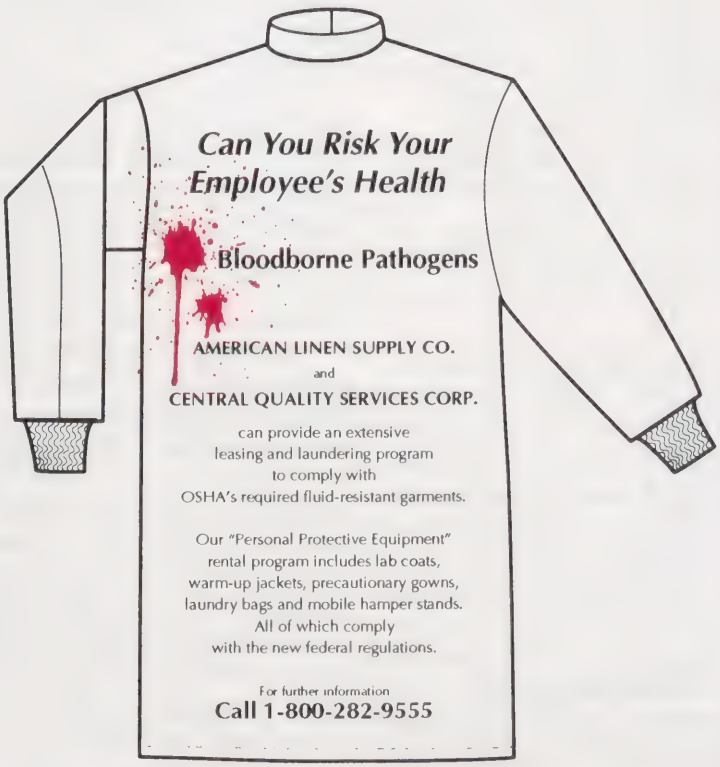
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Continued from page 5

certiorari and unanimously vacated and remanded the case to the Ninth Circuit Court of Appeals for further consideration in light of *Patterson vs. Shumate*. The case clearly indicates that the Supreme Court intends that the protection afforded to ERISA-qualified plan assets applies not only to corporate retirement plans but also to plans established by individual physicians of small professional corporations where the physician may be the trustee and sole participant.

It is important to note that Individual Retirement Accounts ("IRAs") are not ERISA-qualified plans. Therefore, the Supreme Court's decision is not applicable to IRAs. IRAs are protected under Michigan law, which is incorporated under the Federal Bankruptcy Code. Under Michigan law, assets rolled over from an ERISA-qualified plan to an IRA are only protected to the extent that the amount is tax deductible. The Michigan statute and its incorporation by the Federal Bankruptcy Code have not been judicially tested, as have ERISA plans under the United States Supreme Court decisions. Physicians should exercise caution in rolling over assets from an ERISA-qualified plan to an IRA. The Michigan statutory scheme would be applicable, but such a rollover would lose the certainty of protection now enunciated by the United States Supreme Court with respect to ERISA-qualified plans.

LETTERS

Physician profile appreciated

I am writing to express my appreciation for the excellent article which *Michigan Medicine* has done about my "hobby" of sailing and its leading to the discovery of my biological father (See February 1993 issue). I have already received many, many favorable comments about not only the writing of the article by David Fox (MSMS Chief of Media Relations), but also on the quality of presentation. I have requested reprints so that I can share your excellent work with my patients, friends, and colleagues in the future.

As mentioned in the profile, I strongly believe that the philosophy of collaboration and a structured process of patient education are essential to helping solve the problems facing our health care system. Patient education leads to patient-centered care, has a positive impact on risk management concepts, enables patients to make informed decisions, and enhances the doctor/patient relationship.

As you may know from the profile by Mr. Fox, I and my colleague Dorothy Bouwman, MSN, RN, have made a commitment to developing and publishing patient and family education materials. This evolved from my own neurosurgical practice to provide my patients with appropriate education about their illness and treatment options, and to facilitate placing them *at the center of the health care process.* We now have patient education monographs in many specialties, teaching videos, and other educational materials for patients and health care providers.

In appreciation for your efforts, we would like to present you with some of the books, our new "Neurological Anatomy" flip-chart, and also one of our LUDANN caps (which we provide to all our patients). We believe that patient education is key to helping patients become an active member of the health care team and to make a commitment to work toward optimum healing and recovery. I hope that you enjoy wearing the cap for your own outdoor activities!

Again, thank you very much for the privilege of being profiled. I am a faithful reader of *Michigan Medicine* and *Medigram*. The information and indepth articles are always interesting and helpful to me not only as a physician, but as a patient. If I and Dorothy might ever contribute to the effort on behalf of health care as speakers for the MSMS, please do not hesitate to call upon us.

Oliver D. W. Grin, MD, FACS
Grand Rapids

Michigan Medicine praised

Congratulations on the quality of MICHIGAN MEDICINE. It is no wonder that this beautiful and informative journal is an award winner, and you, Henry Domzalski, MD, (chairman of the MSMS Committee on Publications) and your committee...deserve much credit.

Carl A. Gagliardi, MD
LaPlata, Maryland
Past President
Michigan State Medical Society

Physician image articles praised

Just a note to tell you that I enjoyed reading your physician image articles that appeared in the February (issue of) *Michigan Medicine* magazine.

"Think globally, act locally" is a great slogan for many of us.

Carol Jachim, Editor
The Record
Blue Cross/Blue Shield of Michigan

Mini textbook on frostbite available from Alaska State Medical Association

William J. Mills, Jr., MD, an Anchorage orthopedic surgeon, is a world renowned scholar of thermal injuries. He has spent some of his retirement hours summarizing the literature of that field. In the 1970s, Doctor Mills and his associates wrote several papers that were published in *Alaska Medicine*. At that time, *Alaska Medicine* was not listed in Index Medicus.

Alaska Medicine, now indexed, will devote the Volume 35, No.1 to cold injury. The earlier articles will be republished along with his summation of the subject.

I would like to ask that you publish this letter to alert your readers to what we hope will prove to be a mini textbook on frostbite. Your readers may order a copy from our Anchorage office for $10 plus $2.50 shipping and handling. Address: *Alaska Medicine*, 4107 Laurel Street, Anchorage, Alaska 99508.

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MSMS ON THE MOVE

A monthly update of key MSMS activities

MSMS seminar teaches alternatives to assisted suicide

To provide physicians with the most up-to-date information on compassionate care, MSMS has developed "Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide." This seminar will:

- assist physicians in managing symptoms of chronic illness.
- update physicians on the durable power of attorney for health care, withdrawing or withholding life sustaining treatment and the Michigan assisted suicide ban now in effect.
- explore options open to terminally ill patients.
- explore creative approaches to pain management in the elderly.

The first session is April 13 from 9:00 a.m. to 4:30 p.m. at the Radisson-on-the-Lake in Ypsilanti. Other sessions will be held May 26 in Grand Rapids, June 23 in Traverse City, September 29 in Flint, October 27 in Detroit and November 24 in Kalamazoo. The program provides six hours of Category I CME credit. Call the MSMS Office of Physician Education at (517) 336-5784 to register.

MSMS 1993 summer externship catalog available

MSMS this month is completing its annual catalog for medical students on "Hospital Summer Externships in Michigan 1993." It contains information on positions available to these students in hospitals around the state. This includes information on the length of each hospital's program, how many positions are available and the amount of compensation, if any. If you'd like a copy, or know a medical student who would, call Joyce Heldman at MSMS at (517) 336-5747.

MSMS CLIA seminars help doctors with new federal rules

How to comply with new CLIA regulations is a question many physicians are asking. CLIA, or the Clinical Laboratory Improvement Amendments, regulates all laboratories performing in-office testing of human specimens for diagnosis and treatment. MSMS is presenting training seminars on the new requirements this month and next to help acquaint doctors with how it affects them. They'll be held April 19 in Flint, April 20 in Detroit, April 21 in Kalamazoo, May 11 in Grand Rapids, May 12 in Traverse City and May 13 in Marquette. Call MSMS Regulatory Ombudsman Tom Wolff at (517) 336-5740 for more information about CLIA. Call the MSMS Office of Physician Education at (517) 336-5784 to register for the seminars.

MSMS booklet summarizes CLIA regulations

A new MSMS booklet also outlines CLIA regulations for physicians. This valuable reference tool contains information on testing categories, registration certificates, fees, inspections, sanctions and other areas physicians must be aware of to comply. The booklet is available to MSMS members at $10.00 per copy, and to nonmembers at $30.00 per copy. Call MSMS Regulatory Ombudsman Tom Wolff at (517) 336-5740 to obtain your copy.

For details on these and other issues call William E. Madigan, Executive Director, MSMS, 517/337-1351.

MEDICAL NEWSFRONTS

U-M researchers unfold new data on beta-carotene

Nutrition researchers at the University of Michigan and the University of California-Los Angelos have found another reason why health conscious consumers might consider adding a beta-carotene capsule to round out a balanced diet that includes raw fruits and vegetables.

"Clinical studies show that beta-carotene in the pure supplement form is absorbed into the blood stream more efficiently than beta-carotene in raw fruits and vegetables," the researchers said. "It appears that the presence of pectin and fiber in raw fruits and vegetables reduces the absorption levels."

Beta-carotene, a precursor substance that the body can convert to vitamin A, is an efficient antioxidant that wipes out free radicals, thus helping protect against strokes and cancer.

At least one study done in the late 1970s suggested that cooking fruits and vegetables breaks down pectin and enhances absorption, but the extent to which it helps has yet to be determined. U-M researchers are in the process of screening candidates for such a study at U-M right now.

Their findings so far do not suggest that consumers should forget about fruits and vegetables altogether and do their vitamin shopping at the pharmacy.

"Beta-carotene supplements cannot substitute for fruits and vegetables, which contain many other compounds and vitamins required by the body. We also need some fiber to enhance digestion," the researchers said.

State releases 1993 fish consumption advisory

The Michigan Department of Public Health (MDPH) and the Department of Natural Resources (DNR) has released its 1993 sport fish consumption advisory update. The advisory is issued annually to inform the public about which species of fish found in the Great Lakes and surrounding waters contain elevated levels of contaminants.

According to state officials, due to decreased contaminant levels, the health risk associated with the consumption of Michigan fish has declined sharply over the last two decades. For example, DDT and PCB levels in Lake Michigan fish have dropped 80 to 90 percent since the mid-1970s.

"Contaminant levels in many fish species have been decreasing over the past 15 to 20 years," said state health director Vernice Davis Anthony. "As a result, Michigan fish are the safest they've been since we first began sampling them for human consumption back in the early 1970s."

Steady declines in the levels of toxic chemicals in certain Great Lakes fish have led to a serious consideration of removing or easing the restrictions of some advisories, such as those for coho salmon, smaller sized chinook salmon, and lake trout. However, action will not be taken on these advisories this year pending the approval and adoption of a regional protocol for developing fish consumption advisories for the Great Lakes region.

In the meantime, the 1993 Public Health Fish Consumption Advisory will be published in this year's Michigan Fishing Guide.The guide will be available at outlets where fishing licenses are purchased, at DNR field offices and at local health departments throughout the state of Michigan. It may also be obtained by calling the following toll-free number: 1-800-648-6942.

Medical study targets leading cause of blindness in elderly

In a unprecedented collaborative effort, four Michigan medical centers have joined together to determine a more effective treatment for the leading cause of sudden and permanent blindness in the elderly.

"Ischemic optic neuropathy is essentially a stroke to the optic nerve, the master nerve of the eye which carries information to the brain," said David Kaufman, DO, director of the Michigan State University College of Osteopathic Medicine's Neurovisual Unit. "Through this research effort, we hope to learn how to better treat this devastating condition for which no cure is currently known."

The National Eye Institute has designed and funded the four-year study that will compare the efficacy of surgical and non-surgical treatments for the disease. Twenty-six sites located across the country will conduct the research. Along with the MSU Neurovisual Unit, three other Michigan centers will participate - the Kellogg Eye Center at the University of Michigan, Beaumont Hospital in Royal Oak, and Henry Ford Hospital, Detroit.

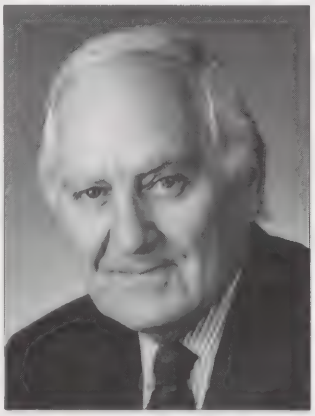
State awards grants to prevent teen pregnancies

State Health Directory Vernice Davis Anthony recently announded that five teen health centers will receive a total of $120,000 in grants to develop programs aimed at combatting Michigan's rising teenage pregnancy rate. They are: · Baldwin Family Health (Lake County), · Ingham County Health Department, · Mott Children's Health Center, Beecher Teen Health Center (Genesee County), · Oakwood United Hospitals, Heritage Hospital, Romulus Teen Health Center (Wayne County), and

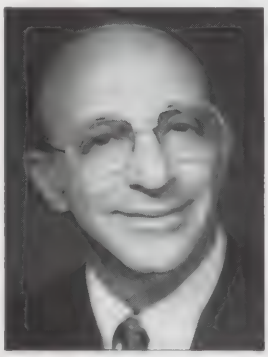
· Sanilac County Health Department,

Continued on page 11

PHYSICIANS IN THE NEWS



Alexander J. Walt, MD,
has been reappointed chairman of the Board of Regents, American College of Surgeons. A distinguished professor of surgery at Wayne State University School of Medicine, Doctor Walt is a member of the Southern Surgical Association, is vice president (1992-1993) of the Society for Surgery of the Alimentary Tract, and is president of the American Board of Medical Specialties. He delivered the Law Lui lecture on "Carcinoma In Situ of the Breast: The Dilemma of the 90s" at the 9th Asian Surgical Association Biennial Congress, Manila, Philippines, in February 1993, and was elected to honorary membership in the Asian Surgical Association.



Philip M. Margolis, MD,
has been re-elected to his second term as chairman of the Michigan State Board of Medicine. An Ann Arbor psychiatrist, Doctor Margolis is active in the Federation of State Medical Boards, and also is on a National Board of Medical Examiners committee. He recently received the Career Service Award presented by the Mental Health Association of Michigan. The award honors his long, distinguished service on behalf of mental health services in the state.

John Bielawski, MD,
was honored recently by the American Heart Association of Michigan for his contributions to research and community education programs. Doctor Bielawski, who is semi-retired, has been an associate professor of medicine at Wayne State University for 44 years.

Kenneth S. Rudman, MD,
is the newly-appointed Interim Medical Director of the Sparrow Pain Center, Lansing. A board-certified anesthesiologist and member of the Sparrow Hospital medical staff since 1986, Doctor Rudman also serves as medical director of obstetric anesthesia and is president of Lansing Anesthesia Associates, PC.

Robert Swanborg, MD,
is the recipient of a seven-year, $1.27 million Javits Neuroscience Investigator Award from the National Institutes of Health. A Wayne State University professor of immunology and microbiology, Doctor Swanborg will investigate brain and spinal cord diseases through 1999.

Robert H. Mathog, MD,
is a newly-named member of the National Deafness and Other Communication Disorders Advisory Council of the National Institutes of Health. Doctor Mathog is professor and chairman of the Department of Otolaryngology-Head and Neck Surgery at Wayne State University. He recently received funding as a principle investigator of a National Cancer Institute grant on the rehabilitation of the head and neck cancer patient and a reseach training grant from NIDCD on research training in otolaryngology. He is the author of the 1992 textbook, *Atlas of Craniofacial Trauma.*

Conrad E. Nagle, MD, FACNP, FACSM,
is president of the American College of Nuclear Physicians. He is chief of nuclear medicine services at William Beaumont Hospital, Troy.

Stephen J. Weiss, MD,
is recipient of the 1993 American Federation for Clinical Research Foundation Young Investigator Award. As E. Gifford and Love Barnett Upjohn professor of Internal Medicine at the University of Michigan Medical Center, Doctor Weiss is a leading researcher at the U-M Comprehensive Cancer Center in the field of proteolytic enzymes and their role in cellular invasion. His research focuses on the role of proteolytic enzymes, which are used by tumor cells to invade healthy tissues.

The Macomb County Medical Society
has elected the following officers for 1992-1993: **Arsenio V. De Leon, Jr., MD,** president; **Kenneth A. Weinberger, MD,** president-elect; **Akemi Takekoshi, MD,** secretary; and **Steve Georgiou, MD,** treasurer.

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Referring Physician Communications

MSMS Reimbursement Roundup

By Joyce Nurenberg
MSMS REIMBURSEMENT OMBUDSMAN

MSMS Reimbursement Ombudsman fields a variety of questions

Q A patient who had not met his deductible refused to pay at the time of service claiming he was told by BCBSM customer service that the physician had to bill BCBSM first. Is this true? Does it matter whether we are participating with BCBSM?

A As a participating physician, you are not required to bill BCBSM first. But Randal Lafevers, program control coordinator, BCBSM, suggests providers bill BCBSM first because, "it will ensure that all approved amounts and charges are applied correctly to the customer's account/contract and will ensure appropriate subscriber liability."

As a participating physician, if you choose to bill the patient at the time of service, you are limited to billing the patient for only the BCBSM approved fee schedule amount, so it is important to have a current copy of the fee schedule in your office.

Deductible information can be obtained through using the Dial-in Eligibility and Network System (DENIS) system, the newly-updated service code manual or by contacting provider inquiry. The *unsatisfied* portion of the deductible can be determined by calling Provider Inquiry. Provider inquiry can provide deductible information as of the current date. By the third quarter of 1993, it is expected that this information will be available to DENIS users.

Q We are non-participating with Medicare in Area 2. By mistake we billed our patients the Area 1 limiting charge. Consequently, we received the Limiting Charge Exception Report from Medicare telling us to refund our patients for the difference. Can we reduce the patient's liability on their account rather then send them a refund?

A It is acceptable to reduce the patient's liability rather than send a refund as long as it does not create a negative balance. Per the Health Care Financing Administration, "a credit balance on a patient's account is not acceptable as documentation of compliance with the limiting charge refund requirements."

Q In the past, returning money to Medicare and BCBSM has been an exhaustive process. Other physician offices have faced similar problems. Our office is tempted to wait until Medicare and BCBSM find the overpayment but are concerned with the repercussions of this as well.

A Money that you or your staff know does not belong to you should be returned. The first safeguard in minimizing problems when returning money is to be sure to mail the information to the proper address. For Medicare, mail checks to BCBSM, Cash Receipts and Adjustments - Mail Code 1007, 600 Lafayette East, Detroit, Michigan 48226-2998. For BCBSM, mail to BCBSM, P.O. Box 366, Detroit, MI 48231. The second safeguard is to include all the pertinent information, i.e, the original check or a personal check, a copy of the voucher and an explanation as to why the money is being returned. **Always** keep copies of the information as well as a copy of the envelope and document the date mailed.

Effective, January 1993, Medicare has begun a new protocol for unsolicited payments returned to the carrier. A letter will be sent acknowledging the refund amount, check number and reason for refund. You will also be given a reference number should your staff have a need to inquire about the check.

Allow four weeks to pass before you begin to worry that the carrier does not have it. If after this time you get no confirmation of receipt after calling provider inquiry, call your BCBSM field representative, Medicare professional relations staff person or call Joyce Nurenberg, MSMS Reimbursement Ombudsman at (517) 336-5722.

Below are some examples of questions received from member physicians and their staff.

Q Our office is having trouble getting co-surgery claims paid from BCBSM. If the other doctor sends his/her claim in first, we have trouble getting our claim paid.

A BCBSM admits that there are problems in getting these claims paid and recommends the following procedures until the process becomes automated:

■ Both surgeon's 1500 claim forms should be submitted in a single envelope

Continued on following page

REIMBURSEMENT ROUNDUP

Continued from page 13

- Each claim form should report modifier "22" in fields 43J, 43I or 43K
- Each claim form should report a second modifier "62" in fields 43I or 43K
- The *number* of pages of attachments (operative report) to each claim should be reported in field 45 of each
- Both claims should be mailed in the same envelope to

BCBSM CLAIMS DIVISION
P.O. Box 250
Detroit, Michigan 48231-2500

Even though modifier 62 is not recognized by the claims systems at this time, it will be helpful in routing of the claims internally to the appropriate area.

Q Our office treated a patient who recently died. Can the patient's wife be held responsible for the medical claims even though we did not have her sign a guarantee of payment?

A Yes. According to the law in the State of Michigan, as established by the Michigan Court of Appeals in *Borgess Medical Center v Smith*, 149 Mich App 796 (1986), a married women is liable to a medical services provider for necessary medical services provided to and contracted for by her deceased husband, even if she did not guarantee payment. This rule of law has not been overturned by the Michigan Supreme Court. This law affects services incurred after March 17, 1986. (Source: Tom Williams, Kerr Russell and Weber, MSMS Legal Counsel)

Q What are the obligations of a deceased patient's estate to reimburse physicians?

A In order to receive payment, the physician's office must file a claim against the deceased patient's estate. Call the office of the clerk of the probate court to secure a supply of the appropriate forms.

In most states, the estate must first pay the funeral and burial expenses of the deceased. If there is money left, the next group of expenses paid will be those generated by the deceased's last illness, including the physician's bill.

If your claim is not for the care of the patient during his last illness, it will be grouped with other general expenses and paid if the estate has sufficient funds. (Source: American Medical News)

Q Our office billed to BCBS a Technical Surgical Assistance (TSA) fee for a laparoscopic cholecystectomy performed in the outpatient hospital and were rejected due to the location. How can we get paid?

A Although the Michigan Uniform Procedure Coding manual (MUPC) shows a "T" next to the procedure, making the procedure eligible for TSA, your patient's contract may only allow it on an inpatient basis. The following is a list of BCBSM accounts that cover outpatient TSA at this time:

Chrysler, Ford (both hourly and salaried), General Motors, BUDD Detroit Diesel, Saturn, UAW, Kmart, MPSERS, 4.0 (Michigan School Employees) 4.0 Plus, Mazda and State of Michigan.

For those physicians who have received rejections, Ray Rebandt, MD Director, Professional Liaison, BCBSM suggests offices send a status claim, billed with a modifier 22. Include the reason for your inquiry and request that your claim be reviewed by a medical consultant. As long as it is a TSA eligible procedure, medical records are not necessary.

The issue has been brought through the BCBSM Liaison Committee and is being investigated by BCBSM to expand the list of accounts that will cover TSA service in the outpatient hospital setting.

Q When billing for arthrocentesis services, procedure codes 20600-20610, should the drug(s) be billed separately to Medicare and BCBSM?

A For Medicare, the fee schedule payment amount for arthrocentesis does not include payment for the drug. Therefore, the physicians should bill and be paid separately for the appropriate "J" code if a drug is administered. BCBSM includes the cost of the drug in their fee schedule payment for those contracts that cover the procedure.

Billing Tips

When statusing claims with attachments to BCBSM, be sure to fill out box 45 with the *number* of attachments. Do not report an "X."

This will reduce the chance of claims rejecting for documentation requirements.

Remember, that the new observation codes 99218-99220 are for initial observation day services only. Watch for future clarifications on billing observation services in *Medigram* and Reimbursement Roundup.

REIMBURSEMENT ROUNDUP

Q I am a specialist and all of my patients are seen as a result of a referral from another physician. Does this allow me to bill all my office visits as consultations?

A Not necessarily. If the referral is a *referral for treatment,* bill a new or established office visit code. If the referral requests your opinion and advice, you have met one of the three criteria with which to bill a consultation. You must meet the following additional criteria:

- The request for the consultation from the attending physician and the need for consultation must be documented in the patient's medical record.
- Your opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician.

A physician consultant may initiate diagnostic and/or therapeutic services.

Reimbursement Roundup addresses third party payor reimbursement issues affecting physician practices. Comments and problems brought to the attention of the Reimbursement Ombudsman are routinely shared with the Liaison Committee with Blue Cross and Blue Shield of Michigan and its Subcommittee on Medicare Carrier Problems.

Have Reimbursement Questions? MSMS Can Help You

MSMS Reimbursement Ombudsman, Joyce Nurenberg, stands ready to assist you with your reimbursement questions. Just call (517) 336-5722.

The Increasing Concentration of Health Care Expenditures

It has long been common knowledge that a small proportion of the population accounts for a disproportionate share of health care expenditures, a phenomenon called *concentration*. A recent article by Marc L. Berk and Alan C. Monheit in *Health Affairs,* winter 1992, calls our attention to this phenomenon once again. Berk and Monheit show that between 1927 and 1987 only five percent of the population accounted for close to 50 percent of health care expenditures. In 1987 a shift occurred: Five percent of the population accounted for 58 percent of health care expenditures, and the top one percent of all users accounted for 30 percent.
Source: Public Sector Consultants, Health Policy Bulletin, March 1993.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

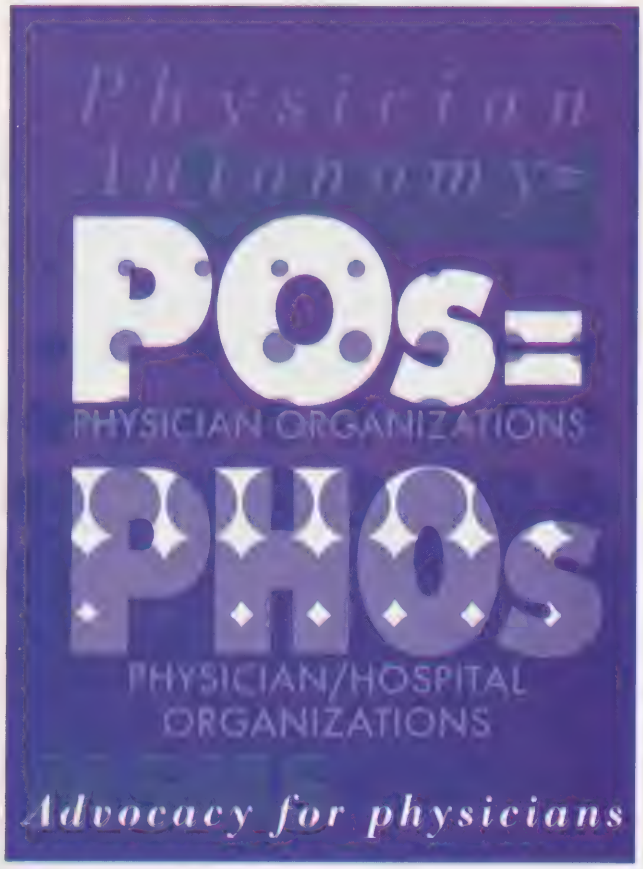
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Physicians, Hospitals, and Managed Competition

The Beginning of a New Era in Medicine



By William E. Madigan, Executive Director, Michigan State Medical Society

Following years of debate among health policy analysts and others, the question has shifted from *whether* the U.S. health care system should be changed to *how* it should be changed. The election of Bill Clinton, followed by the formation of a health system reform task force headed by the first lady, Hillary Rodham Clinton, has elevated the level of debate and has made it apparent that fundamental change in our health care system is likely to occur -- sooner rather than later.

In my eighteen years with MSMS, I have witnessed a number of changes in the medical practice environment and, with the MSMS physician leadership and staff, have been challenged to develop programs and services to meet the changing needs of our members. Without in any way minimizing the seriousness of the issues that we've confronted together in the past, the next few years could produce more fundamental change than occurred over the past two decades combined; change that will affect not only current MSMS members, but generations of Michigan physicians to come.

Although there are many details that need to be addressed, a consensus appears to be emerging around the concept of "managed competition" as the philosophical foundation for the U.S. health care system of the future. While less objectionable in theory than a Canadian-style, single-payer system, managed compe-

tition could be just as threatening to physicians and patients -- if physicians and their professional associations do not take an active, leadership role in shaping the way in which such a system operates. An AMA report describing managed competition and highlighting some concerns for physicians is among the articles appearing in this *Michigan Medicine* cover story.

As in past periods of change and uncertainty in the medical practice environment, MSMS has taken a proactive stance on this issue and has initiated a series of educational, practice assistance, and advocacy efforts on your behalf. Last year, MSMS established a Task Force on Physician-Hospital Organizations (PHOs) to study the potential for PHOs to serve as a means for the delivery of high quality, cost-effective care. The task force concluded that PHOs represent a potentially powerful strategy for safe guarding physicians' clinical autonomy, while working cooperatively with hospitals to provide services in a manner that best serves patients' needs.

> "An invasion of armies can be resisted, but not an idea whose time has come."
> -- *Victor Hugo, 1852*

As an outgrowth of the Task Force's effort, a standing Committee on PHOs has been established and MSMS has taken an active advocacy role in fostering the development of PHOs throughout the state. As part of this effort, PHO focus group sessions are being planned for this spring and will be followed by a conference on PHOs in the fall. Also, MSMS has begun providing assistance to our members in negotiating with hospitals and other entities and is establishing a network of experienced attorney and business advisors to assist MSMS members in managed care contracting and in other practice matters. The lead article in this *Michigan Medicine* cover story describes some of the new MSMS services that are being introduced in an attempt to "level the playing field" for physicians.

An article by attorney and health policy consultant Tom Gorey examines several models of "integrated health care delivery," including the PHO model. In his article, Gorey describes the potential advantages of PHOs, including their role in empowering physicians to meet the health care needs in their communities, and also highlights some of the critical success factors for PHOs.

This issue of *Michigan Medicine* represents only a first step in our effort to keep you informed of important developments regarding managed competition and PHOs, and to advise you of possible strategies for adapting to the changing practice environment. Particularly because of the potential for PHOs to preserve and strengthen physician autonomy, we plan to take whatever steps we can, on your behalf, to foster the development of PHOs in Michigan. It is our goal, through continued educational efforts and direct assistance in contracting and PHO development, to position Michigan physicians favorably for likely changes in the health care system.

I encourage you to read the articles in this issue carefully and, if you have not done so already, to begin to consider the potential advantages of a PHO approach to health care delivery in your community. Given all of the changes that are taking place in our health care system, and the apparent consensus that is forming around managed competition, PHOs may well be "an idea whose time has come."

New MSMS Service Will Help "Level the Playing Field" in Contract Negotiations

By Ralph Ward

As a group, Michigan's physicians are skilled, dedicated and savvy practitioners. But when it comes to complex agreements with hospitals, health maintenance organizations (HMOs) and preferred provider organizations (PPOs), physicians too often find themselves behind the eight ball. Says Fred E. Patterson, MD, of Jackson: "Most doctors concentrate on the practice of medicine, and are not as skilled as they should be in evaluating contracts and other opportunities." Fortunately, as chairman of the new MSMS Committee on Physician Organizations, Doctor Patterson is in a position to do something to help these physicians.

The Committee, which first met in January, has two major purposes. One purpose is to provide support for individual physicians, group practices and medical staffs in contract negotiations with the major corporate health care entities mentioned above. The second purpose is to help physicians establish Physician Organizations (POs) and Physician-Hospital Organizations (PHOs).

The need for physicians to become savvier negotiators has grown sharply as centralization of health care providers and cost-cutting pressures have too often left physicians vulnerable. **To aid physicians, Tom Wolff, MSMS Chief of State Government Affairs and an attorney, is available to advise physicians concerning a proposed contract with hospitals, HMOs and PPOs.** Says Wolff: "MSMS members can call me and I'll talk with them about proposed contracts, or they can send me a copy of the proposed contract, and I'll review it." There will be no charge for this service. It should be noted that physicians who have more complex cases may be referred to outside legal counsel. In these cases, physicians will be responsible to make their own payment arrangements. MSMS also is developing a list of expert consultants in the fields of accounting, strategic planning and management consulting which it will make available to physicians upon request.

In addition to assisting individual physicians, MSMS will work to develop POs and PHOs, not just to give physicians collective contract muscle, but to aid in leading local health care reform.

Several POs have already been formed in Michigan, with the most common unit represented being a hospital medical staff. Each, however, will be unique to the needs of its members, as will the terms of the contracts arranged. "We don't seek to endorse any relationship," says Doctor Patterson. "Each will be unique. There are no cookie-cutter approaches." To assure a fully voluntary, "open shop" approach, says Doctor Patterson, membership in POs and PHOs must be offered to all members of the medical staff. However, membership should not be automatic and will be available only to those who support the PO. MSMS also will help assure proper structuring of the groups. The PHO governing board, for example, should be composed of elected representatives from the PO and the hospital. In addition, the PHO should be structured to ensure that physicians have control over all medical issues, including quality assurance and peer review.

The MSMS Physician Organizations Committee will take a number of steps to nurture a statewide PO and PHO network. A national information database on POs and PHOs already in operation is in the works, and a focus group session in the planning for this spring will develop a group of experts on the topic. A PO/PHO conference this fall will bring together members for discussion and seminars. MSMS staff will gather and disseminate information on state PO/PHO activities, and will target specific sites for PO/PHO development. F.B. "Tom" Plasman, MSMS Manager of Physician Hospital Relations, is spearheading the MSMS effort to develop POs and PHOs.

Ralph Ward is a Lansing-based freelance writer.

MSMS services help physicians with contract negotiations, formation of POs and PHOs

The MSMS Physician Organizations Committee has started a new service to provide physicians assistance in contract negotiations with hospitals, HMOs and PPOs. Call Tom Wolff at MSMS at (517) 336-5740 for details.

Physicians interested in starting talks on PO and PHO formation in their areas should contact Tom Plasman at MSMS at (517) 336-5724.

PHOs

Enhanced Health Care Delivery Through **Physician-Hospital Cooperation**

By Thomas M. Gorey, JD

Physicians, medical society executives, hospital administrators, policy analysts, health care consultants, and others who have been involved in any way with the U.S. health care delivery system over the past decade have seen the emergence of wave upon wave of three-letter acronyms, each holding the initial promise of bringing significant improvement to our health care system. Although some of the concepts underlying these convenient acronyms have become a permanent, if not totally accepted, part of our health care system, such as HMOs and PPOs, none – either alone or collectively – has resolved the underlying weaknesses inherent in the current health care system.

Therefore, it is not surprising that any new three-letter acronym purporting to hold the potential for improving health care delivery is unlikely to be accepted with blind faith, but rather will be met with skepticism, apathy, distrust, or outright hostility by physicians and others with a stake in the future of health care in the United States. Skepticism on the part of physicians is even more likely if the idea is based on the fundamental notion of overt cooperation and joint risk-taking with hospitals. Recognizing that skepticism may be the safest mental framework with which to approach any suggestion for improving the U.S. health care delivery system, and conceding that no approach that can be reduced to a three-letter acronym is likely to solve all of the problems associated with the current system, PHOs (Physician Hospital Organizations) warrant careful consideration as *one* approach to addressing the issue of how best to deliver high quality, cost-effective health care services in a competitive, cost-conscious health care environment.

What is a PHO?

Simply put, a PHO is a business entity formed jointly by a hospital (or hospital system) and a group of physicians for the purpose of pursuing one or more cooperative ventures (often managed care) designed to improve some aspect of health care delivery in the community. Unlike the MeSH concept that was popularized some years ago, the physician unit that participates in the PHO is not necessarily, nor ideally, the hospital medical staff. Rather, it is a group of physicians with a strong loyalty to a particular hospital, as well as common goals, values, and a shared vision for health care in their community, which can be realized only by working cooperatively with a hospital entity with similar interests. If the paradigm for hospital-physician relations in the 1980s was competition, the paradigm for the 1990s, which is encompassed within the PHO concept, is cooperation; that the patients in a community will benefit most if physicians and hospitals, as the primary providers of health care, work cooperatively toward shared goals in a "win-win" framework.

Critical to an understanding and acceptance of the PHO concept is that, to be successful, it must be based on the trust, mutual respect, and shared goals of the physician and hospital participants. Unlike other integrated or community care concepts that have been advanced, which explicitly or implicitly provide for a predominant role for the hospital entity, equal physician-hospital participation in all aspects of governance is central to the PHO model.

Also, unlike some other integrated delivery system models that have been suggested for the delivery of health care services, PHOs offer the advantage of maximum flexibility in structure and purpose. **Most importantly, if structured properly, a PHO can provide physicians with the opportunity to maintain control over the clinical aspects of medicine, while taking advantage of their hospital's administrative and marketing expertise and access to capital.** Rather than expending efforts on competitive, oftentimes adversarial, physician-hospital relationships, PHOs provide the opportunity for cooperative endeavors, taking advantage of the unique skills, expertise, and perspectives of each party to the arrangement. A joint needs analysis for the local community, followed by development of a focused strategy for meeting those needs through a PHO arrangement, offers a potential solution to a community's medical needs which not only does not compromise or threaten the interests of a physician

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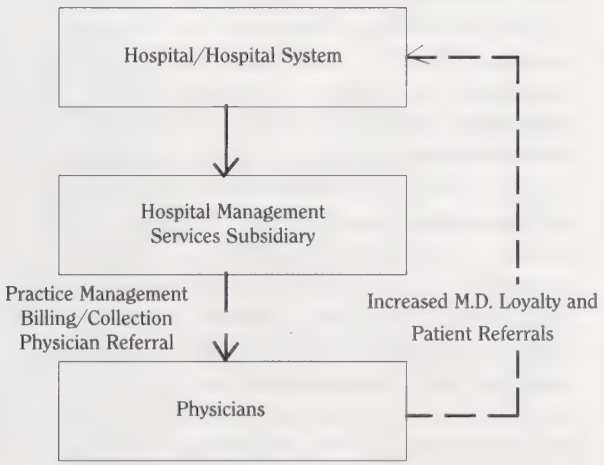
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group or hospital, but in fact provides the best opportunity for ensuring the long term viability of each party while meeting the most pressing medical needs in the community.

Integrated Delivery Systems

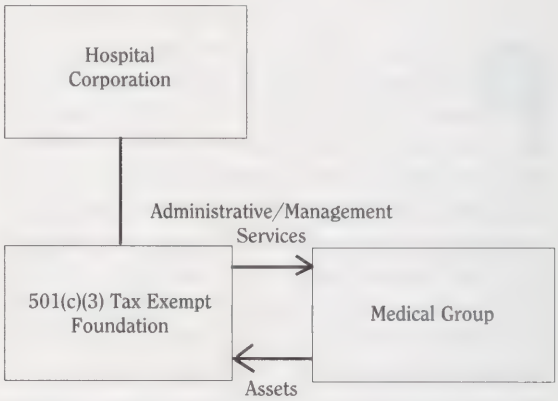
To understand fully the potential advantages of PHOs, it is important to view them in the context of the full range of options for so-called integrated health care delivery. At one end of the spectrum are what are sometimes referred to as "affiliation arrangements" and "management services organizations." Under such arrangements, hospital provides management services to physicians (e.g., practice management, billing, physician referral), either directly (affiliation arrangement) or indirectly through a hospital subsidiary (management services organization), with the expectation or hope that the physicians receiving such services will feel a greater sense of loyalty to that hospital which, in turn, will lead to increased patient referrals to that facility. Although such arrangements can be mutually beneficial to hospitals and physicians and may promote good will, the parties involved are motivated primarily by their own self-interest and, typically, there are no explicit shared goals to be achieved through such ventures. Perhaps most importantly, such arrangements do not provide a mechanism to take advantage of opportunities for managed care contracting.

Figure 1
Management Services Organization



At the other end of the integrated delivery continuum is the foundation model. Under the foundation arrangement, the hospital forms a 501(c)(3) not-for-profit foundation and purchases the assets of a medical group and, in some instances, builds or acquires its own clinical facility. The foundation then provides a full range of management and administrative support services to the medical practice and, in return, the medical practice generates patient referrals to the parent hospital. Under such an approach, there is a greater unity of purpose and greater potential for managed care contracting than under the looser affiliation or management services models. However, the physicians practicing in this environment clearly sacrifice a substantial measure of autonomy and experience an almost certain loss of control over many day-to-day practice decisions.

Figure 2
Foundation Model



Advantages of the PHO Model

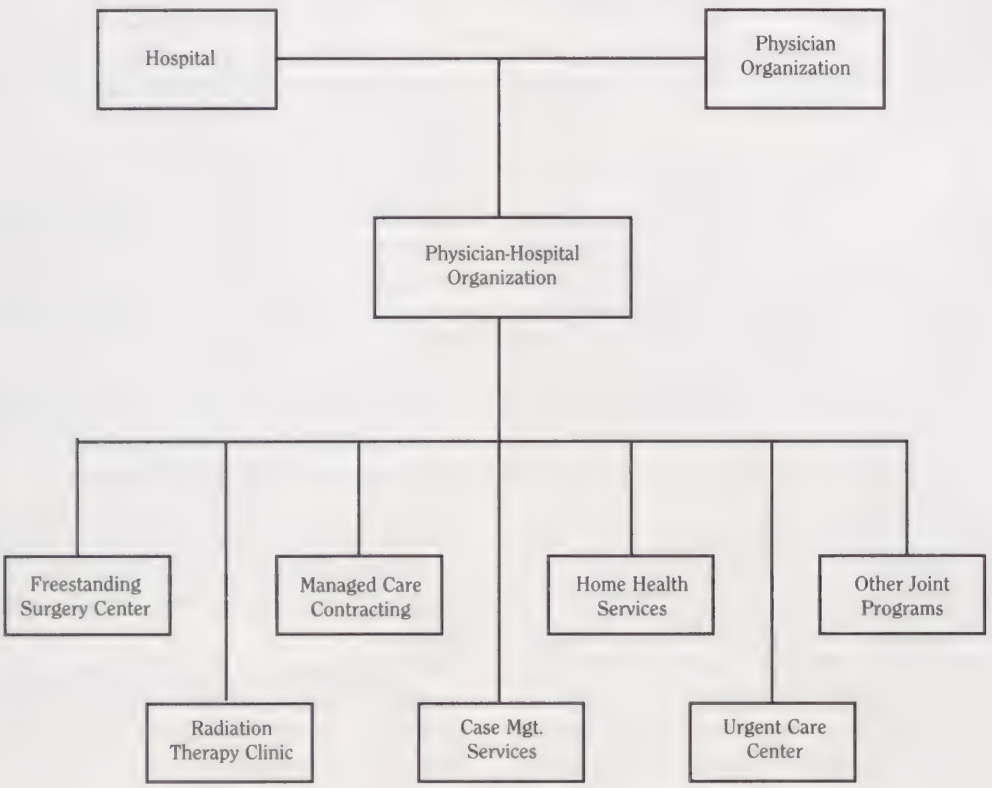
The PHO model, which is in the middle of the spectrum of integrated delivery systems, can be a successful strategy for joint physician-hospital ventures of all kinds that avoids many of the potential problems associated with other approaches to integrated health care delivery. PHOs can be formed to pursue virtually any activity that will meet the common goals of a hospital and a physician group, while serving the needs of the residents of the community at-large, such as operation of a freestanding surgery center, ambulatory care facility, or home health care service. **A key advantage of PHOs is that they allow physicians and hospitals to jointly assess the health care needs of a community, in consultation with community and business leaders, and to cooperatively design and implement programs that best meet those needs.**

For hospitals, PHOs offer the opportunity to expand and diversify their scope of services without competing with their medical staff, to generate physician loyalty and an expanded patient referral base, to reduce the financial risk of selected new ventures, and to improve their ability to secure and retain managed care contracts. **PHOs offer physicians a number of potential benefits,** including: the ability to take advantage of the marketing expertise, administrative resources, and "name recognition" of a local hospital; the opportunity to devote increased time to the clinical aspects of medical practice and less to the administrative "hassles" that have increased in intensity in recent years; an expanded managed care patient base; the ability to participate in joint decision-making on the delivery of health care in the community and to develop new sources of revenue; and the opportunity to play a direct role in ensuring that the quality of care provided to patients through a managed care arrangement or through other PHO-operated ventures is uncompromised.

A principal reason for physicians and hospitals to consider formation of a PHO, particularly in the current political and business climate, is the advantage PHOs offer in managed care contracting. Although it is impossible to predict precisely how the current health reform debate will evolve, it is likely that some form of managed care will be a key component of whatever "solution" is arrived at. Already a handful of states have enacted health reform legislation providing for some type of integrated health care delivery networks. As more and more risk is shifted from public and private payers to health care providers to deliver a "basic" or "minimum" package of benefits to a defined population at a fixed cost, physicians and hospitals will have a growing incentive to develop a managed care "product" that can be marketed successfully in a competitive, cost-conscious health care environment.

Taking advantage of the PHO approach allows a group of physicians and a hospital to become a single, integrated negotiating entity that can compete more

Figure 3
Physician-Hospital Organization (PHO)



Continued from page 21

effectively for managed care contracts than either could be dealing with payers individually. Finally, by utilizing a PHO as a mechanism to provide health care services, the physicians and hospital involved are more likely to recognize the interrelatedness and interdependence of the various components of the health care system and to pursue other integrated approaches to meeting the health care needs of their community.

Although over the past year there has been a growing interest in PHOs, the concept is not a new one. Integrated delivery systems, including PHOs, have been in operation in various parts of the country for a number of years. Although many have been initiated by hospitals, physicians have played a leading role in the development of some of the more well-known integrated systems, including the Henry Ford Health System in Detroit, the Marshfield Clinic in Wisconsin, the Ochsner Foundation in Louisiana, and the Geisinger Foundation in Pennsylvania.

Key Factors in PHO Success

What are the keys to development and operation of a successful PHO? Although PHOs have only recently begun to attract serious attention from health policy analysts, it is clear that there are several factors that are essential to achieving a favorable outcome from PHOs.

■ **Identification of Need** - Establishing a PHO just to establish a PHO will almost surely doom the venture to failure. Both parties to the arrangement, the physician group and the hospital, must take the time to lay the necessary groundwork through a thorough needs analysis. This will necessitate a several stage process whereby the physician group and the hospital group each address their own needs and goals separately and then establish a dialogue to determine where there are commonalities of interest between physicians, the hospital, and the local community; that is, areas where, through joint physician-hospital effort, not only will their own goals be furthered, but the needs of the local community will more likely be met.

■ **Shared Vision and Commitment** - Although identifying joint business and financial needs and opportunities is an essential step in the formation of a PHO, it is equally critical that the physician group and hospital articulate a shared vision for health care at the local community level which can best be achieved through the cooperative effort of the two parties. By participating in the process of developing a shared vision for health care in their community, the physicians and hospital involved will increase the likelihood of identifying ventures that will enhance their own interests while furthering the needs of their patients. Taking the necessary steps to ensure full support and commitment to the shared goals of the PHO by each member of the physician entity is essential to the success of the new venture.

■ **Shared Financial Stake** - In addition to a shared commitment to the goals of the PHO, there must be a shared financial stake. Although it is not essential, or oftentimes feasible, for there to be a 50-50 financial contribution, the arrangement should be structured so that each participant is making a serious commitment evidenced by more than a token financial contribution.

■ **Clear Identification of Goals, Objectives and Strategies** -Identifying patient care needs and developing a shared vision for health care delivery in a community should lay the groundwork for developing a well-articulated strategic plan that sets out clear goals, objectives, and strategies for the PHO. Although the process of forming a PHO in and of itself can perform a useful role in strengthening the bond between a hospital and a group of physicians, over time absent measurable, tangible results, the relationship between the two entities is likely to revert to the status quo prior to formation of the PHO or perhaps deteriorate even further. A necessary factor for the long-term success of the PHO, therefore, involves the development of criteria for the ongoing evaluation of the progress of the PHO in meeting agreed-upon goals and objectives. To increase the likelihood of a PHO being successful in the long term, it is advisable for the parties to begin with a set of narrow, focused (and perhaps even modest) goals that will lead to some early successes, solidify the new relationship, and create the momentum for more ambitious projects.

■ **Utilization of an Appropriate Organizational Model** -Although all PHOs possess certain fundamental organizational attributes, one of the attractive features of PHOs is that they provide a substantial degree of flexibility in design and function. This inherent flexibility should be utilized effectively to ensure that the PHO meets the unique needs of the physician group, the hospital, and the community involved.

■ **Clarification of Roles/Responsibilities** - In deciding to form a PHO, there has to be an explicit recognition of the fact that the two entities bring different backgrounds, perspectives, biases, and ex-

pertise to the venture. This, often coupled with a history of adversarial relations between the participants, will present initial, and sometimes ongoing, challenges to the PHO. However, these challenges can be overcome if the PHO is structured so that the role of the physician in clinical decision-making is affirmed and strengthened and the expertise of the hospital in business administration and marketing is acknowledged.

■ **Governance** - The PHO must be structured to provide for an equal voice by the physician and hospital entities in decision-making. This includes, at a minimum, providing for an equal number of physician and hospital representatives on the Board. In some cases, adding additional at-large members to the Board can help avoid stalemates and build consensus.

■ **Avoidance of Legal Pitfalls** - Although PHOs offer considerable advantages to physicians and hospitals, they are not without financial and legal risk. As a result, it is essential that proper legal and business advice be obtained prior to forming, or discussing forming, a PHO. Separate, expert legal counsel should be retained by the physician group and the hospital, and each party should be well-informed of all terms of the arrangement including, most importantly, potential risks associated with the PHO.

Summary

In light of the many trends that have been building over the past decade and the current pressures on the health care system for reform, change is inevitable in the way medical and other health care services are delivered and financed. Regardless of the precise nature of those changes, increased cooperative effort between physicians and hospitals in providing health care at the community level will be critical in ensuring the future success of the health care system. PHOs represent one potential approach to increased health care integration at the local level which can offer significant advantages to patients, physicians, and hospitals. Although PHOs are not a panacea for the ills facing the U.S. health care system or for deteriorating physician-hospital relations, they can be a solid building block for a stronger health care system and for improved, cooperative relations between health care providers.

Thomas Gorey is president of Policy Planning Associates.

Highlights from an AMA report

Managed Competition

Some Concerns for Physicians

At the request of the Board of Trustees of the American Medical Association, the Ad Hoc Technical Advisory Committee on Health System Reform (TAC) undertook a study of managed competition. Some key results of the study are highlighted in the following report. The study presents a discussion and evaluation of a generic managed competition system and does not reflect any particular legislative reform proposal. The report provides a definition of managed competition and discusses assumptions underlying managed competition health system reform proposals. It reviews the strengths and weaknesses of managed competition, AMA policy, and managed competition reform proposals. Finally the report contains recommendations for AMA policy.

Managed Competition Defined

Managed competition refers to a system of health insurance wherein sponsors, i.e., collective agents on the demand side of the medical and insurance markets, make a defined contribution toward the purchase of insurance for each individual that they represent. In theory, an agent could be a sponsor. In practice, proponents of managed competition have variously identified federal agencies, state agencies, private employers, and labor-management health and welfare trusts as proposed sponsors. Typically, more than one type of sponsor is stipulated in any given managed competition proposal.

In a managed competition system, a sponsor's defined contribution is a single, predetermined dollar amount which it will apply toward the purchase of any health insurance for which it contracts on behalf of the individuals it represents. The defined contributions serve both as an incentive for insurers

Continued on following page

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to compete and as a lever by which sponsors can more directly affect their premium expenditures. Proponents of managed competition typically attempt to affect competition by tying defined contributions to the cost of a least expensive plan providing coverage for at least a basic set of benefits. In addition, sponsors could affect total premium expenditures by establishing limits on coverage over and above the basic set of benefits.

In general, managed competition proposals have sought to expand access as well as to institute mechanisms for cost control. Employer-mandates are common though not universal among managed competition plans. Typically, the uninsured would be brought into the system through public sponsors. In many instances, public sponsors would also serve as purchasing agents for small employers. Finally, the establishment of new information systems for assessing such variables as outcomes, provider performance, and cost-quality tradeoffs can be found in several prominent managed competition proposals.

Managed competition, however, is distinct from managed care. Managed competition is a health insurance system distinguished by collective purchasers whereas managed care, as defined by the AMA, refers to systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services (Policy 285, 998 *AMA Policy Compendium*). A managed competition system could be implemented through managed care plans; however, such a system could theoretically incorporate other types of plans as well. Many managed competition proposals have been structured around "integrated systems." An integrated system is one in which the administrative, delivery, and financing activities associated with an individuals' health care are performed by a single entity or one in which incentives are structured to effectively channel patients through such entities. Examples of the entities that have been proposed to perform these integrated activities include insurers, insurer-provider partnerships, and health insurance purchasing cooperatives.

AMA Policy

The degree of consistency between managed competition and existing AMA policy depends upon how the concept of managed competition is implemented.

Managed competition could be consistent with a variety of AMA policies. The notions of consumer choice of health plan and delivery mode (Policy 165.960 (5)), increased cost consciousness among consumers (Policy 165.960 (4)), broadened access (Policy 165.960 (2)), and economic competition as the market organizing force and the promoter of efficiency (Policy 165.960 (4)) are all consistent with current Association policy. Where managed competition plans include an employer mandate (Policy 165.983) or limit the tax deductibility of employer contributions toward premiums (Policy 165.960 (12)), there is additional congruence.

The AMA has encouraged state and county medical associations to work with employers, health insurance carriers, and health care coalitions in their jurisdiction to facilitate the formation of Multiple Employer Trusts (METs) to allow small employers to offer or purchase adequate health insurance coverage directly. The AMA has additionally called for those associations to work with appropriate organizations in those states that do not regulate the fiscal solvency of such trusts to encourage enactment of legislation to provide such regulation. METs are one possible structure for small-employer sponsors (Policy 165.992 (3)).

However, the possibility also exists that managed competition could be implemented in ways that are inconsistent with AMA policy. **One concern is that public policy might favor managed competition relative to other approaches.** AMA policy is that the same rules of competition should apply to all competitors, including insurance carriers and self-insureds (Policy 165.960 (7)). The logic is that free-market competition should determine which delivery and financing systems succeed. Thus, any system which gave managed competition a competitive advantage through tax policy, governmental regulation, or governmental policies would be inconsistent with AMA policy.

Another concern is that sponsors of managed competition might not implement effective quality assurance mechanisms. AMA policy clearly calls for all health care institutions to establish a formal structure and process to evaluate and enhance the quality of health care services and that the structure and process should include professional staff, management, patients, and the general public (Policy 450.994 (3)). The existence of effective quality assurance mechanisms is particularly important for managed competition systems because the focus on cost containment might lead to erosion in quality standards. Thus, managed competition systems would be inconsistent with AMA policy unless they ensure that the delivery systems with which they contract have effective quality assurance mechanisms.

A third concern is the potential impact of managed competition systems on the structure of

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Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS: Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy: Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE: Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992 5890

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care would be inconsistent with AMA policy, if it were to limit patient freedom of choice or physician ability to select mode of practice. If the current legal constraints which deny physicians an effective negotiating role are not removed, this is an especially serious concern.

Relevant policies include:

1. The patients' freedom of choice of physician or health care delivery system (Policy 160.977 (1)),

2. Physicians should retain the right to choose their method of earning a living (Policy 165.960 (8)), and

3. Employers must offer their employees a choice among benefit payment schedule (indemnity), UCR, and pre-paid plans (Policy 165.960(II-B)).

The AMA will vigorously continue to seek the role of negotiating agent for patients and physicians (Policy 385.973 and Policy 165.960 (11)).



MSMS President Thomas C. Payne, MD, (right) talks with Tipper Gore about the difficulties Michigan physicians encounter in trying to recruit and retain doctors. Doctor Payne was among the three dozen panelists and some 300 audience members during a March 22 forum attended by members of the White House Task Force on Health Care in Dearborn.

Concerns for Medicine

Managed competition proposals should contain mechanisms to ensure that sponsors solicit contracts from a sufficient number of insurers to ensure competition does take place. In addition, they should ensure that sponsors solicit and support a sufficiently wide spectrum of insurers to reflect the preferences of, and range of risks represented by, their constituents.

Typing defined contributions to managed care plans rather than true least cost plans will undermine some of the competitiveness in the insurance market. In addition, it will instill a bias in the system in favor of managed care plans.

Proposed information systems should not impose undue burdens on patients or physicians. Physicians will want to ensure that reporting requirements are limited to factors appropriate to treatment and payment decisions. Confidentiality issues and physician cost under such systems will need to be critically examined. The development of any such information system should involve physician representatives and may be extremely costly.

Proposals which seek to establish provider-insurer partnerships lack specificity as to the envisioned role of providers generally and physicians in particular. They would appear to put physicians into either weak ownership positions with respect to the partnerships, without any possibility for representation by organized medicine, or into pure employee positions.

Recommendations

The AMA Board of Trustees recommends that:

1. The AMA adopt the following policy position: Health system reform proposals that concentrate unfairly the market power of payors are detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payor systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payors and physicians or be opposed.

2. The AMA continue to support pluralistic health care system, with no preferential treatment by government that gives a competitive advantage to any form of health insurance/health care delivery organization. In particular, integrated systems, as defined in the report, should be given no competitive advantage.

3. The AMA propose and support legislative or regulatory action requiring employers to offer a benefit payment schedule plan, in addition to other plans.

4. The AMA continue to advocate strongly to Congress, the Department of Justice, and the Federal Trade Commission, the need for changes in relevant antitrust laws to allow physicians and physician organizations to engage in group negotiations with collective purchasers, managed care plans, insurers and other payors.

5. The AMA make support for any "managed competition" proposal contingent, in part, on:

· relief from existing antitrust laws with respect to the right of physicians and physician organizations to engage in group negotiation and

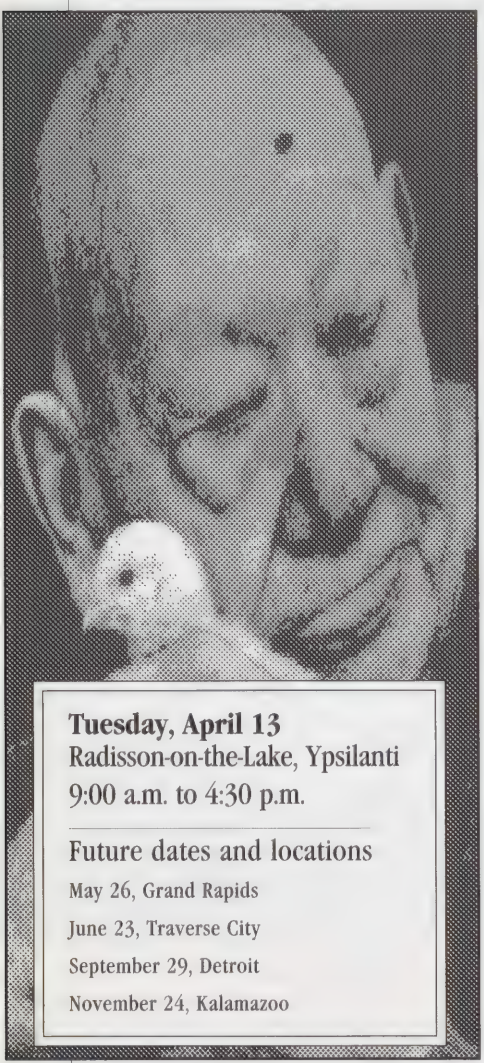
· modifications to ERISA to ensure that any rules and negotiation requirement apply equally to self-insured and insured health benefit plans.

6. That the AMA study appropriate means of risk indexing and adjusting premiums used under any "managed competition" proposals.

7. The balance of this report be filed.

MSMS Committee on Bioethics

Continues to Study Alternatives to Assisted Suicide



Tuesday, April 13
Radisson-on-the-Lake, Ypsilanti
9:00 a.m. to 4:30 p.m.

Future dates and locations
May 26, Grand Rapids
June 23, Traverse City
September 29, Detroit
November 24, Kalamazoo

Resolution to the dilemma of physician assisted suicide is still a long way off. In the meantime, regardless of the ethical and moral concerns accompanying the issue, patients and physicians alike have agreed that alternatives to assisted suicide exist. These alternatives will be explored at a just-developed MSMS seminar on "Effective Compassion for the Incurably Ill." The seminar, which is recommended for all health care professionals concerned with managing chronic pain, will be offered numerous times. The seminar will debut April 13 at the Radisson-On-the-Lake in Ypsilanti. (See sidebar for future dates and locations.)

In the following Michigan Medicine *special report, John V. Hartline, MD, member of the MSMS Committee on Bioethics, will describe some of the alternatives to assisted suicide. Following his article, John Finn, MD, director of Southeastern Hospice, will explore the choices provided by Hospice.*

Compassionate Alternatives for the Terminally Ill

By John V. Hartline, MD

Recent attention given to the terminally ill has focused on the timing and circumstances of death. Regardless of one's position on the issues of suicide or assistance in suicide, there are a number of principles of patient care which can help address compassionate care for suffering or terminally ill patients. The Committee on Bioethics feels that increased attention in these areas will give patients assurance and confidence at times when serious and/or terminal illness must be addressed.

Who should decide

Patients should have assurance that their wishes are considered when important decisions have to be made. In this area, physicians need to help the public understand health care decision making. The patient with the ability to participate in his/her own health care decisions must be the decision maker. Family members must see their role as supporter of the patient and know that it is unethical to exclude information from the capable patient. Patients also need assurance that their wishes will be

heeded if they are unable to actively participate and choose. In that others, usually close family members, are consulted in these circumstances, individuals should inform their family members and close friends of their desires. If the patient's treatment choices can be reasonably ascertained by the physician, then the treatments given will represent those which the patient would choose.

The public should be made aware of an additional method available in Michigan to assist patients if they are unable to actively participate – the Michigan Durable Power of Attorney for Health Care. Although this document is neither required nor essential to good decision making, the process can be easier for all concerned with its use. This document is based on the ethical principle of autonomy, the right of self-determination. Self-determination in health care decisions may be extended into the period of time when the patient is unable to actively participate by two methods.

Durable Power of Attorney for Health Care

One, the Durable Power of Attorney for Health Care enables the patient to select the individual who will be the decision maker should he/she become incapable of deciding. That individual will have all the authorities of the patient were he/she able to participate. Michigan's law provides authority for the durable power of attorney.

Living wills

The second method, the living will, enables the patient to delineate what actions he/she would want or not want taken in specific circumstances. The Michigan document requires patients to indicate their desires regarding life-extending treatments and it also provides space for other specific instructions. In those areas, the document is similar to the living will in that it gives specific direction to the power of attorney and physicians regarding the specific areas addressed. By federal law, all adult patients are queried as to the existence of advance directives at the time of admission to a health care institution. Patients with such documents are asked to furnish a copy on admission. Patients without are given educational materials regarding advance directives. The documents are not required for admission or treatment and may not be mandated. Such documents are not required for physicians to proceed if the patient's desires have been reasonably ascertained from previous discussion with the patient or from family and/or close friends.

Patient desires key

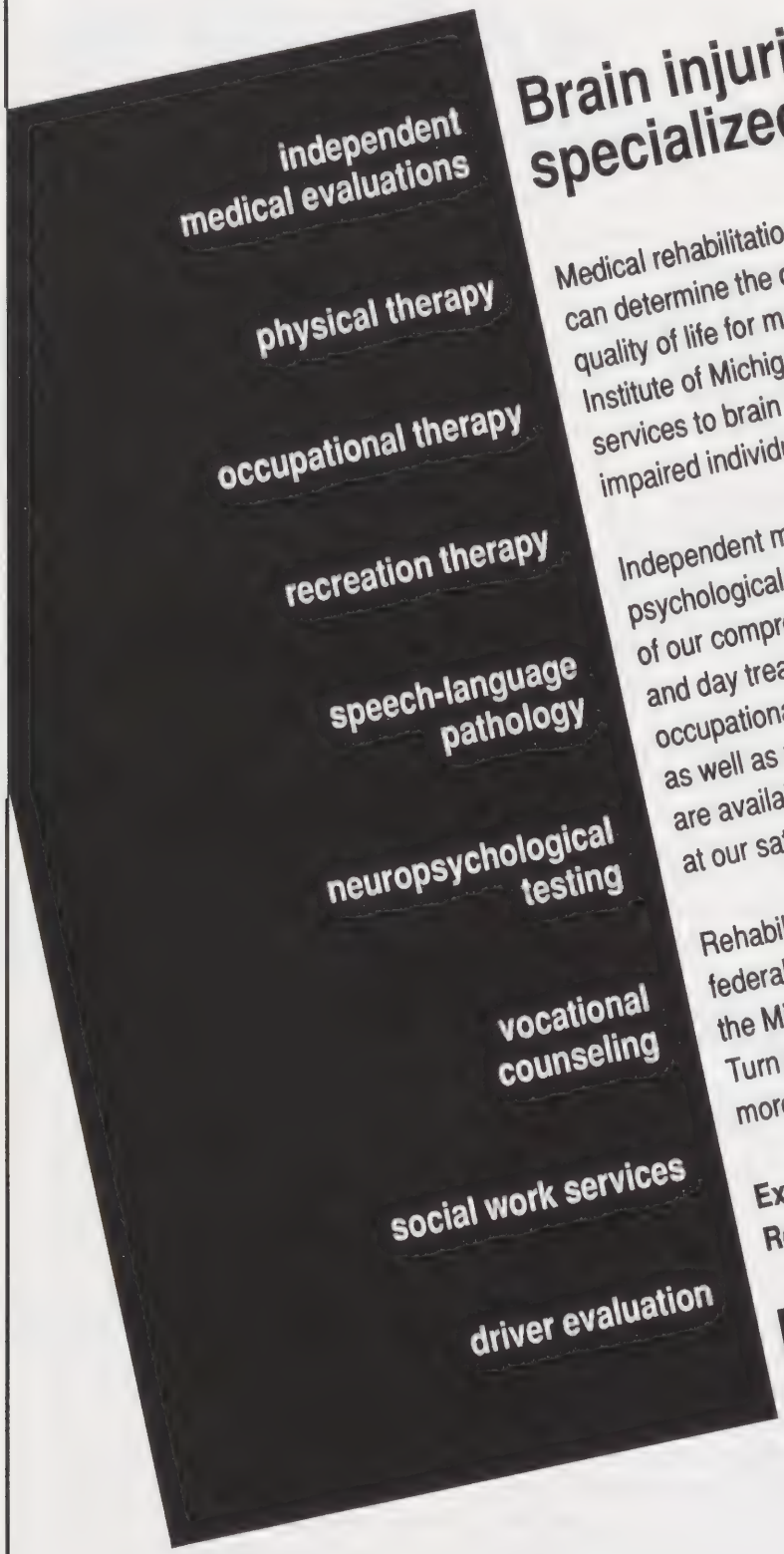
Often patients are very concerned as to how treatment decisions will be made. Many are concerned that undesirable, aggressive interventions would be used when they would like comfort care. Others want assurance that modern technologies will be considered. The Committee on Bioethics stresses the need for physicians to address these topics in a timely and yet sensitive manner with their patients. Additionally, physicians need to work with hospitals, nursing homes, and emergency response personnel (e.g., ambulance companies or fire departments) to effect policies to assure adherence to patients' desires and directives when applicable.

Another duty of the physician is the relief of suffering. Suffering includes pain, fear, anguish, anticipation of deterioration or dependence, and loss of self-esteem.

Adequate pain control can be achieved in most patients using modern understanding of pain and its consequences. Nevertheless, use of inadequate amounts of pain medication has been implicated as the most significant form of "drug abuse" in the care of the terminally ill. Pain and the fear of pain can and should be treated aggressively. Physicians should use the amount of medication required to adequately treat the patient's pain. Shortening of life may be an unintentional, albeit not unanticipated, consequence in some cases. Nevertheless, consistent with the doctrine of double effect, the unintentional death of the patient is acceptable in that the medications are given to treat the pain, not to effect the death of the patient. It is not appropriate to limit pain medication in the pain-suffering patient out of desire to avoid addiction or of concern regarding effect on respiration. Of course, the patient (or advocate for the patient) should have dealt with the "code/no code" issue before this time.

Patients also suffer from the psychological impact of illness. The physician's duty toward the relief of suffering defines this area of the doctor-patient relationship. Newer diagnostic methods such as genetic testing may make patients aware of anticipated illness, e.g., Huntington's Chorea. Biochemical or radiological testing may confirm diagnoses of neurological conditions earlier in the course of the disease. Individuals may be aware of the consequences of a specific illness through their experience with previous or existing patients within the family. In addition to the impact on the afflicted, patients often are well aware of the influence of the illness on the unaffected family care-givers and of the resources consumed in the process. They may have seen the deterioration of a loved one's physical and/or mental capacity from self-sufficiency to total dependency. Compassionate caring and care in these circumstances are essential and most challenging. Depression and anxiety may respond to counselling and/or medication. Concerns regarding future venues for care may be alleviated through patient participation in the exploration of alternatives with family and physician. Preparation of advance directives may help the patient maintain a sense of control. In all these and other interventions directed toward the psychological aspects of suffering, the close relationship between patient and physician seeks ways for the patient to find meaning and benefit from this life.

Continued on page 29



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Continued from page 27

The MSMS program, "Compassionate Alternatives for the Terminally Ill," addresses potential means available to the physician treating suffering and/or terminally ill patients. Respect for the principle of autonomy requires physician expertise in diagnosis, treatment options, prognostication, and communication to assure patients of having adequate information upon which to formulate their choices. Compassionate caring in the physician-patient relationship will preserve the patient's dignity and alleviate fears of abandonment.

The Committee on Bioethics feels that emphasis on the autonomy-supportive, beneficence-based role of the physician in the care of the terminally ill may serve to limit the desires of patients to seek active ends to their lives through suicide or assisted suicide. Programs should be on-going to educate all physicians dealing with terminally ill or suffering patients regarding the spectrum of resources available to the patient and family. Additionally, the Committee sees a need for a just and fair social policy to be enacted that assures care in a humane and respectful venue without devastation of family resources.

Doctor Hartline is a Kalamazoo neonatologist and a member of the Michigan Ethics Resource Network.

DPA Forms Available from MSMS

Durable Power of Attorney for Health Care Designation Form and accompanying brochure can be obtained in quantity from MSMS. Price is 40 cents for the pair when ordering 100 or more. Under 100, the price is 45 cents. Minimum order is 50. Quantities 10 and under are available at two dollars per set. To order, or for more information, contact Linda Beck at MSMS (517) 336-5783.

Management of the Dying Patient: The Hospice Alternative

By John W. Finn, MD

We physicians are not trained to think of death - a peaceful death - as a therapeutic goal. Yet, that goal is the most responsible and compassionate medical response to a patient with incurable and progressive illness, associated with a limited life-expectancy. The dying process can be competently managed, without interventions intended to directly cause death.

The current physician-assisted suicide debate reflects how extensively our mismanagement of dying pervades the medical experiences of society. In a *Detroit Free Press* poll, 52 percent of 900 residents in metropolitan Detroit were in favor of physician assistance in dying; specifically, a physician administered lethal injection to a competent, terminally-ill patient on demand. This majority of public opinion is a result not only of shifting morality, but more importantly of physician and health care institutional failure to:

1. Listen and take seriously patient's preferences for treatment.

2. Encourage advance directives, such as living wills and Durable Power of Attorney.

3. Confront futility and bravely withdraw or not initiate technologies or treatments, which merely prolong the dying process.

4. Adequately control pain and other distressing symptoms.

5. Function as a coordinated team to comprehensively address other components of the dying process, which magnify suffering (emotional, financial, spiritual).

6. Lend physical and emotional support for the family.

7. And, finally, accept dying and death as a part of life.

Hospice programs effectively assist physicians with these problems. In explaining the hospice philosophy of care and its role in our health care system, it is useful to consider three medical models. These are the curative, supportive and symptomatic models. Each approach is active and aggressive and requires diligent application of medical science and art.

In this century we have become quite accomplished at the curative model. A patient develops an acute, life-threatening illness, which would have been certainly fatal in the past (e.g., appendicitis with peritonitis and sepsis). With definitive intervention, the patient is restored to previous levels of health. Often there is no sparing of cost or patient suffering.

Similarly, we have become expert at the supportive model with the advent of modern medical therapies and interventions. A patient develops a life-threatening illness, for which there is no cure (e.g., juvenile-onset diabetes mellitus). Treatment of disease-related complications can convert an otherwise fatal disease to a chronic one. Supportive interventions with antibiotics, nutrition, etc., can prolong survival, which hopefully translates into enhanced and ongoing quality of life.

In the situation of terminal illness, however, both the curative and supportive models are generally inappropriate. There is neither potential for restoration of health nor possibility of prolongation of survival with quality of life. Attempts to intervene merely prolong the dying process and add to the suffering. Unfortunately, much of modern medicine is preoccupied with these futile attempts, when the therapeutic

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goals ought to be focused on comfort and ultimately a peaceful death. Physicians recognize this dilemma and often violate their own conscience or common sense for lack of a symptomatic model, which is best characterized by hospice.

Death a natural part of life

Hospice care (aka Palliative Medicine - a recognized specialty in the United Kingdom) is competent, compassionate and comprehensive management of the dying patient. Death is viewed as a natural part of life, and is neither hastened nor postponed. Pain control is of primary importance. Invasive technologies are usually avoided and generally unwanted by the patient and family. Death usually occurs at home predictably and peacefully to the astonishment of caregivers.

We have lost sight of the wisdom and mercy of a "natural death" at home as well as the science and art of symptomatic care in this technological age, when most patients die a "medical death" in hospitals and nursing homes, often in discomfort with futile interventions. **The current interest in assisted suicide would quickly cease to be an issue with public and physician awareness of the hospice alternative.**

There are just two hospice admission criteria: terminal prognosis and consent. The later is by far the most important and the former problematic. Terminal illness is commonly equated with a prognosis of less than six months. Many physicians are uncomfortable or unwilling to certify such a prognosis and over estimations of the time left occur commonly. The median length of stay for a patient on most hospice programs is less than three weeks. A more useful definition is any incurable illness which is progressive and associated with a limited life expectancy (perhaps one to two years). This expanded criteria would ensure that patients and their families benefit from hospice services longer than just the last few days of life.

The more important hospice criteria is consent; this is, a patient and family who determine for themselves that their medical goal is relief of symptoms and not prolongation of life. This is an autonomy issue and assumes the patients family is knowledgeable about the illness, treatment options, including hospice care, and likely outcomes (full disclosure and informed choice). It is regrettable that few patients are made aware of the hospice option and that physicians lack familiarity with the concept of care.

Hospice services provide for a team of professionals (nurse, home health aide, social worker, counsellor, volunteer and chaplain) who assist the attending physician to manage the terminal process successfully. Referring physicians are encouraged to continue following their patient and to direct medical management. The Hospice Medical Director is available to consult on a problematic symptom or to make home visits. Regular communication between the team and physician assure that patient and family needs are comprehensively addressed.

The physician's principle role is relief of distressing symptoms, particularly pain. The World Health Organization estimates that between 50 and 80 percent of patients with advanced cancer in developed countries suffer pain needlessly, largely due to underprescribing of available analgesic medications, such as morphine. Yet, approximately 80 to 90 percent of cancer patients obtain adequate relief of pain when morphine is given orally in sufficient doses on a scheduled basis. When properly prescribed, the feared complications of respiratory depression or addiction do not occur. Patients, especially those who are imminently dying, have a right to effective pain relief. **Physician reluctance to adequately provide analgesics is unethical medical practice. Persistent requests for physician aid in dying become rare when patients receive good pain management.**

Over 90 percent of the time, death at home is peaceful. In the minority of cases, troublesome symptoms occur, such as rapidly rising opiate requirement, terminal agitation and respiratory congestion, which can be adequately managed with simple measures. Most patients usually become increasingly frail with diminished intake, yet hospice patients do not complain of hunger or thirst. As intake volume decreases the level of consciousness drops. Families can be reassured that the natural dying process is comfortable and predictable. Patients "die in their sleep" within two weeks when fluid intake is less than 1000 cc per day. In contrast, patients who die in hospitals with full supportive care are massively edematous, hyper-alert requiring restraints, and subject to endless interventions and associated complications. Simple intravenous fluids can prolong the dying process by up to six weeks, thereby adding to suffering. Without hospice support, families of these patients hold on to unrealistic hopes of recovery and are caught unprepared when death does occur. Hospice families benefit from ongoing support from the hospice team as well as 13 months of bereavement follow-up, which includes frequent telephone and mail contact, support groups and counselling for grief therapy.

A positive alternative

Hospice is the positive alternative in the euthanasia/assisted suicide debate. It is not passive euthanasia, or assisted death. Rather, it is sound and appropriate management of the hopelessly-ill patient, consistent with our professional creeds and ethics statements. Hospice is opposed to legislation of any medical intervention intended to directly result in death. It affirms patient's rights to refuse unwanted intervention, adequate symptom control, and peaceful death.

Doctor Finn is medical director of Southeastern Hospice and is president of the Michigan Pain Society.



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MEDICAL INQUIRER

DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS from the MSMS Department of Medical Economics and Health Care Delivery

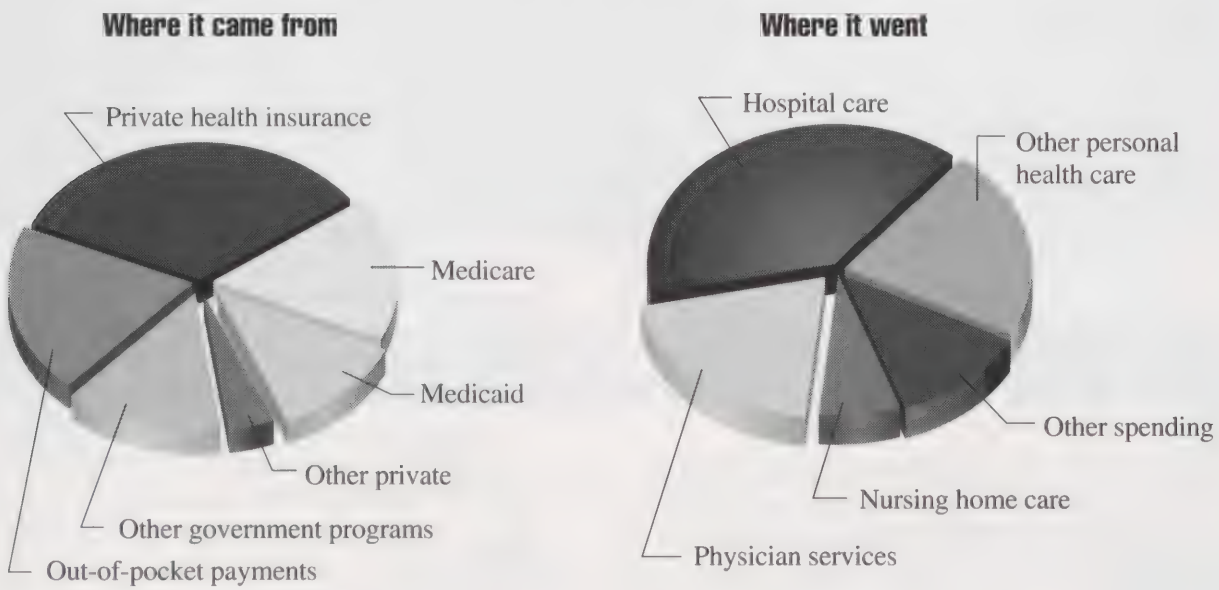
Health Expenditures: Considering All the Costs

Physician payments have been under close scrutiny in the last five years, particularly by the federal government through the Medicare program. After DRGs were enacted to hold hospital costs down in the 1980s, the government looked to the Resource Based Relative Value Scale (RBRVS) to redistribute payments among specialties and the Medicare Volume Performance Standard (MVPS) to control growth of the Medicare budget. However, serious health reform and cost control mean that there are many areas of health care that require attention.

National Health Expenditures

Examination of how the health care dollar is being spent highlights the major categories of expenditures.[1] Hospital care consumes the largest portion of the health care dollar at 39 percent. Although one-fifth of the dollars are spent on physician services, the category of other personal health care is slightly larger. This category includes dental, other private professional services, home health care, drugs and other non-durable medical products, vision products and other durable medical products. Another 12 percent goes to other spending, such as program administration and the net cost of private health insurance, government public health, and research and construction. Nursing home care consumes 7 percent of dollars spent.

The Nation's Health Dollar
1991 (Projected)



Continued from page 33

Although the category of other personal health care encompasses many smaller segments of the health care market, together they represent projected spending of $276 billion by the year 2000, with another $85 billion projected for administrative and private insurance costs.

Factors that Add to Health Care Costs

Some of the causes of high cost care are outside the control of either physicians or hospitals, but instead result from the external environment in which medicine is practiced.

Social Problems: The health care system exists to cure illness, but many of the problems physicians see have a root in social problems. Lack of prenatal care and good nutrition, domestic violence, obesity, smoking and drug/alcohol abuse, sedentary lifestyles–all of these byproducts of the social environment end up in the emergency department or physician office. Although the popular media has picked up on the interest in healthier lifestyles, it is still up to the individual patient to make lifestyle choices that affect personal health and consumption of health care resources: 23 percent of Americans smoke, 26 percent do not use seat belts, 15 percent engage in binge drinking, and 59 percent have a sedentary lifestyle.[2] Life expectancy has increased over time, meaning that chronic diseases associated with aging have risen as well.

Defensive Medicine: This includes marginal or unnecessary tests and procedures that are performed in order to protect against a malpractice suit. The AMA estimated that these defensive practices cost $15.1 billion in 1989. A report issued by the National Medical Liability Reform Coalition estimates the savings from tort reform at $34 billion over five years.[3] What cannot be measured are the costs associated with the restriction of practice to low risk patients or procedures to reduce the chance of a suit, or the loss of physicians to early retirement.

Patient Preference for Aggressive Treatment: Although there is no quantifiable data, the tendency for Americans to ask the physician to do whatever they can to treat illness has an impact on total costs. The modern miracles of transplants, high-tech heart procedures and elaborate diagnostic tests are very expensive. If a treatment is available, there will be a demand for it regardless of the costs. Although this puts the U.S. on the cutting edge in treatment, it also taxes the resources that are available to everyone.

SOURCES:
[1]Sonnefeld, Sally T., et al. Projections of National Health Expenditures through the Year 2000. *Health Care Financing Review*, Fall 1991.
[2]*Facts about Hospitals and Health Care in Michigan, 1985-1990.* Michigan Hospital Association Michigan Health Care Institute.
[3]Estimating the Costs of Defensive Medicine. Lewin-VHI, Inc., January 27, 1993.

For further details on trends and sources of information, please contact Julie Lester at MSMS.

MSMS MD data

MSMS SURVEY ON PRACTICE CHARACTERISTICS

Look to the May issue of Michigan Medicine for complete results of this MSMS Survey on Practice Characteristics conducted by the MSMS Department of Medical Economics and Health Care Delivery.

Topics covered include:

Medical Liability

- type of coverage
- number of suits and outcomes
- judgments over insurance limits
- per case and annual coverage limits
- premiums

Time Spent on Call

Uncompensated Care Provided by Physicians

Impact on Third Party Payer Regulations on Medical Practice

Staffing and Resources

- full-time and part-time staff
- average salary
- turnover

Practice Environment

- physician supply
- effects of competition
- personal satisfaction

Community/Environment

- frequency of health problems
- patient concerns
- environmental problems



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Beginning with the very first blueprints, The James was designed to provide researchers with the facilities, technology and opportunity to conduct their best work. Today, it is a reality that is dedicated to offering hope to the current generation of cancer patients as well as the promise of eradication to those in the future.

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Michigan Drug Utilization Review and OBRA 90

By Mary Sandusky

Drug Utilization Review (DUR) is not new in Michigan. Michigan Medicaid began operating its DUR program in 1985. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) will cause some changes to occur. OBRA 90 requires every state to have a Drug Use Review Program including the establishment of a Drug Use Review Board effective January 1, 1993.

DUR Board

Michigan Medicaid's DUR Board has been established and the first meeting was held in September, 1992. The Medicaid agency requested recommendations to serve on the Board of the Michigan Department of Social Services (DSS) from the Michigan State Medical Society (MSMS), Michigan Association of Osteopathic Physicians and Surgeons (MAOPS), Michigan Pharmacist Association (MPA) and the Michigan Merchants Council (MMC). It is important that the Board represents a cross section of both physician and pharmacy providers that are impacted by the DUR program. All persons recommended by the respective organizations were approved and are currently serving on the Board.

OBRA 90 requires that the DUR Board be composed of at least one-third, but no more than 51 percent, licensed and actively practicing physicians and at least one-third licensed and actively practicing pharmacists. The Board consists of seven voting members, three physicians, three pharmacists, one Medicaid representative. In addition, the coordinator of the DUR program serves as staff for the Board. The Board is scheduled to meet on a quarterly basis once the bylaws are established and DUR criteria has been approved.

Richard Henderson, MD, Frank Check, MD, and Diane Morris, MD, (alternate) represent MSMS on the Board. Doctor Henderson and Doctor Morris also serve on the DUR committee which meets on a monthly basis to review patient profiles for the retrospective DUR program. Doctor Henderson has served on this committee since its inception and brings a great deal of knowledge and expertise regarding the DUR program to the Board.

The DUR Board acts in an advisory capacity to the Michigan DSS. Its primary purpose is to develop policy recommendations in specified areas of DUR. To this end, the DUR Board will:

- Review and make recommendations for approval of predetermined standards for prospective and retrospective review programs.
- Make recommendations on educational topics for practitioners on common drug therapy problems if needed to improve prescribing or dispensing practices.
- Re-evaluate and, if necessary, make recommendations for modifications of interventions.
- Evaluate and make recommendations for identified cases brought before the Board for resolution.
- Submit an annual report to the DSS that contains specific required information.

Prospective DUR and patient counseling

The Board is responsible for approving predetermined standards for use in the prospective DUR program. Prospective DUR occurs at the point of sale and refers to the review of drug therapy before dispensing. Before prescriptions are filled or delivered, the pharmacist must review the consequences of the drug therapy based on standards from the following:

- American Hospital Formulary Service Drug Information
- United States Pharmacopedia - Drug Information
- AMA Drug Evaluations, or
- Peer reviewed medical literature

The availability of pharmacy computer software programs and stand alone drug interaction software will enable pharmacists to fulfil the prospective portion of OBRA 90. For those pharmacies which do not own a computer, the Board is responsible for approving standard compendia.

The pharmacist must conduct an immediate therapeutic screening for drug therapy problems specified by OBRA 90 such as drug-drug interactions, duplicate therapy, contraindications, etc. Some software programs require contact with the physician prior to dispensing the medication. Therefore, interaction with the physician will occur more often during the prospective review of the patient's drug therapy.

Maintaining patient records, prospective review and patient counseling support quality assurance with the ulti-

mate goal of enhancing patient therapy and therapeutic outcomes. Some pharmacies, in addition to oral counseling and written material given at the time of dispensing, have made available drug information dispensing machines that allow customers access to drug and disease information.

Education intervention

Michigan Medicaid has contracted with Health Information Designs (HID) to establish an education intervention program that meets the requirements of OBRA 90. HID will apply predetermined standards approved by the DUR Board to drug claims data to generate reports that provide the basis for retrospective education intervention.

The responsibility of the DUR Board includes:

- identifying educational topics if education on common drug therapy problems is needed to improve prescribing or dispensing practices;
- recommending the mix of interventions (telephone, written, face-to-face) that would most effectively lead to improvement in the quality of drug therapy; and
- evaluating and approving education materials used in face-to-face intervention.

Upon approval by the DUR Board, HID will carry out the educational programs and interventions.

Retrospective DUR

The most significant change will be the approval by the DUR Board of therapeutic criteria used to identify cases for review. All approved criteria must be non-proprietary and will also be documented on each individual profile.

The retrospective DUR program will maintain the same structure, however there have been significant changes in the content of the patient profile that will enhance the DUR committee's ability to review and appropriately identify cases for intervention. The additional information provided includes:

- brand and generic name description
- prescription number
- amount paid for drug claim
- estimated Mg/day
- days supply
- hospital length of stay
- physician specialty

The DUR profiles are reviewed by DUR committees comprised of physicians and pharmacies. There are currently three committees that meet on a monthly basis to determine if drug therapy appears to be medically and therapeutically appropriate. If the committee decides a recipient's apparent drug therapy-induced illness, the physician(s) and/or pharmacists involved will be informed by letter.

Summary

The DUR Board's role in the Medicaid DUR process is significant. With the requirements for membership on the DUR Board and the responsibilities directed by OBRA 90, the standards will ensure that they reflect the accepted medical practice and are clinically relevant to the geographical area represented. The DUR Board has the potential to improve drug utilization review and ultimately improve the quality of care. The approval of criteria for both patient retrospective and prospective DUR and the addition of education intervention will help us to improve the quality of care.

DSS encourages your input and participation on the DUR regional committees. There are currently three committees that meet monthly and are located in:

- Detroit
- Ann Arbor
- Lansing

Please contact Tom Wolff (517) 336-3740 at MSMS if you are interested in serving on one of the DUR committees.

Mary Sandusky, a registered pharmacist, is DUR coordinator.



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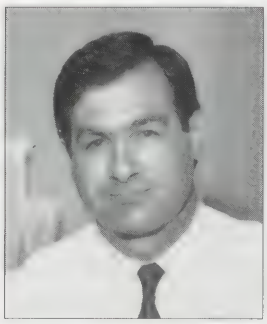
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THE PROs AND CONs of Informed Consent and HIV Testing

PRO

Informed consent should be required before HIV testing

By Ronald M. Davis, MD



Doctor Davis

At the 1992 Annual Meeting of the Michigan State Medical Society's House of Delegates last May, the House adopted two resolutions which called for the elimination of the state's current statutory requirement for informed consent prior to HIV testing. Similarly, the American Medical Association's House of Delegates has adopted the position that "explicit consent should not always be required prior to HIV testing" (Board of Trustees Report BB, June 1992).

These policy statements, adopted after rather heated debate, do not reflect the significant disagreement that exists within the medical profession on this issue. As AMA trustee Nancy Dickey, MD, has stated, "Physicians are split. There has not been a great deal of change in either side." (*American Medical News*, October 26, 1992) Moreover, the position of organized medicine obscures the overwhelming support that appears to exist for mandatory informed consent among those who specialize in the prevention and treatment of HIV disease.

The Michigan Department of Public Health (MDPH), the Michigan Association for Local Public Health, the Michigan Association of Public Health Physicians, and the Michigan Society for Infection Control support a continuation of the requirement for mandatory informed consent prior to HIV testing.

In brief, arguments in favor of requiring informed consent prior to HIV testing include:

1) The social stigma and discrimination (in employment, insurance, housing, etc.) associated with HIV infection justify informed consent prior to testing. That stigma and discrimination make HIV infection unique, which runs counter to the argument that HIV infection should be treated as any other communicable disease or sexually transmitted disease.

2) The requirement for informed consent provides a valuable opportunity for counseling people about how to reduce or eliminate the risk of acquiring or transmitting HIV.

3) Most patients, with proper pretest counseling, will consent to be tested. The few who do not should be treated as presumptively positive (as should all patients), according to the concept of universal precautions.

4) If testing without informed consent is allowed in private medical offices, informed consent will still be required in testing sites that receive federal funding (which is a condition of receiving the federal funding). This would set up a two-tiered system in which those tested in private medical offices would have fewer rights than those tested in public sites.

5) If the requirement for informed consent prior to patient testing is eliminated, patients will understandably push for testing of physicians without their consent. In other words, the MSMS and AMA policy on informed consent undermines our ability to oppose mandatory testing of physicians (a position on which we all agree). This point should not be underemphasized as there are forces in the state legislature and in Congress that have been pushing for mandatory HIV testing and/or disclosure of HIV status for health care workers.

In my opinion, **this issue is like that of physician-assisted suicide. These matters are so complex, emotional, and potentially divisive that we should be very cautious when we consider changing the law.** MSMS recommended a cautious approach on legal remedies to the matter of physician-assisted suicide; in the same vein, we should be cautious before seeking a change in the law on informed consent prior to HIV testing.

The public health community in Michigan, and our department in particular, look forward to participating in continued discussions of this issue.

Doctor Davis is chief medical officer for the Michigan Department of Public Health.

CON

Current HIV / AIDS testing policies barriers to care

By Steven E. 'Olchowski, MD



Doctor Olchowski

Since the medical profession became aware of the Human Immunodeficiency Virus and the subsequent Auto Immune Deficiency Syndrome (AIDS), pressure groups from outside of medicine have influenced law, policy, and patient care. AIDS is a communicable disease. A position, obvious to most physicians, took five years to be recognized as such by the AMA. But, because AIDS is incurable and contagious, physicians are told by special interest groups how to identify the people who carry the virus.

The victims of AIDS are treated by society as almost folk heroes. Their status is close to that of veterans of foreign wars who have lost their lives defending our country. The rights of individuals who may have the HIV virus are so protected that inmates that are known to be HIV positive aren't segregated from the rest of the prison community. It is not inconceivable that any time spent in jail, for any crime committed, has the potential to become a death sentence.

Medical charts and records are confidential. **There is no agenda on the part of health care workers to expose patients with positive test results. The knowledge gained is important for the care and protection of the health care workers themselves, the patients, and the people that come in contact with patients that test positive.**

The hysteria associated with five patients who were infected by one Florida dentist captured the headlines and forced a cry for mandatory testing of health care professionals just last year. It is still unknown the exact manner of transmission from the dentist to these five individuals. However, there are 32 documented cases of health care workers who have been infected by patients with the HIV virus. There is no doubt that being a health care worker places us in a high risk category for contracting the Auto Immunodeficiency Syndrome.

It is very easy to set down guidelines and principles for treatment that will be carried out by someone other than you. The case for universal precautions is argued eloquently by non surgeons across the country. It is my opinion, that universal precautions are tedious, time consuming, and costly. To modify technical behavior in the operating room to such an extent poses a real threat by technical misadventure to patients undergoing surgery. You can look at the situation from a variety of ways but the bottom line remains, the surgeon is the one who does the cutting, and the sewing, and it is the surgeon that is at risk from injury.

There are several studies showing in cases where there was no suspected HIV infection the incidence of a hole in gloves was 10 percent. In cases where HIV infection was suspected, perforation of gloves was five percent, but in cases where HIV infection was known to be positive the incidence of glove damage was zero. Just one more example of how you can't legislate human nature.

I believe HIV testing should be a broad based screening tool applied much the same way syphilis testing and tuberculosis skin testing were performed in the past. If this cannot be implemented then HIV screening should be performed at least as part of a routine pre-operative evaluation. The informed consent procedure is very time consuming, embarrassing, uncompensated, and creates a stigma of its own. I believe a more "business as usual" approach to HIV testing would foster a less hysterical way of identifying patients who are zero-positive and be more reassuring to the public at large.

It is my opinion that this country has slipped so far to the left in protecting the rights of the individual that we risk the health of the majority.

■ Post-test counseling must be performed by a physician whenever it is performed at Cottage Hospital. Infection control is available as a resource.

■ Never give results over the telephone. Try not to give results on a Friday as the patient may need the support of resources which are not available over the weekend.

Doctor Olchowski is a Detroit colo-rectal surgeon.

Offers Telephone On-Hold-Message-And-Music Systems

What do your patients hear when they are put on hold?

By Mike Roth



Hello! Doctor's office, could you please hold for a moment? When patients call your office and are placed on hold, what do they hear?

SILENCE - Your patients may feel ignored, and for many, 30 seconds of silence can seem like three minutes. Telecommunications industry studies also indicate a higher rate of call abandonment for callers listening to silence while on-hold.

RADIO - Your patients may be listening to static from an untuned station, negative news reports, silly or controversial disc jockeys, songs with questionable lyrics, commercials promoting alcohol use and self-prescribed medications, and...you may also be breaking copyright laws.

TAPES OR CD's - Copyright laws require payment of royalties to agencies such as ASCAP (American Society of Composers Authors and Publishers) or BMI (Broadcast Music, Inc.), if you play radio or tapes and CD's over your hold line. If you don't pay these fees you are liable under copyright infringement laws. Many companies have been sued for damages up to $10,000 for each song infringed, and ASCAP boasts that it has never lost a lawsuit.

Ideally, every patient who calls your practice should be helped immediately. However, this ideal situation is not realistic the majority of the time. Wouldn't it be nice if there were some way to use your "on-hold" time to promote a positive image of your practice, allowing you to thank, educate, entertain, inform, and reassure your patients while they are on-hold. Professionally produced message-and-music-on-hold systems can help! Studies indicate that at least 50 percent of callers placed on-hold are less likely to hang up or abandon the call when listening to a pleasant and informative message-and-music mix. **Surveys have found that over 80 percent of callers prefer on-hold messages and music to other hold options, and will remain on the line an average of three to four times longer than callers who hear plain background music.** Phone on-hold systems are almost like having an extra receptionist who specializes in informing

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What to look for

What to look for when you're shopping for a message-and-music-on-hold system. First is the type of system you choose. One is a basic tape player hooked to your phone system in the same way as a radio. Continuous loop tapes are used to then deliver your message-and-music programs. The second, more sophisticated option, is a digital system. The message-and-music tape is automatically downloaded onto a digital chip, which then plays the information to callers who are placed on-hold. A digital system may be slightly more expensive, but offers many advantages. Loop tapes wear out over time and can break or stretch, and sound warped or distorted. Also, the tape player requires maintenance and will eventually need to be replaced. A digital system needs no maintenance and requires playing the tape only once. The chip doesn't wear out and provides a superior sound quality and allows the building of a program library.

An effective message-and-music-on-hold system will reflect the professionalism and personality of your individual practice. In addition to the content of the messages, a professional voice talent will make your message statements more appealing.

The length of an on-hold program is generally three to six minutes in length, with four minutes being the industry standard. Approximately six statements or messages, interspersed with music are combined to make a program that repeats about every four minutes. The production should be professional and of broadcast quality, provided by experienced voice talents and pleasant background music that is positive and bright. The announcers should be friendly, courteous, and easy to understand. The messages should be current, accurate, technically correct and produced in a timely fashion. **The company providing a message-and-music-on-hold program should use licensed music on your hold system.** A good on-hold-message-and-music company should provide quality equipment and offer a full warranty on the equipment and the production. The company should also call periodically to check on the quality of your installed system. Your on-hold provider should also offer a variety of options including a number of voice talents, both male and female, professional script writing, instruction and installation hardware, special rates for multiple locations, and a good track record of satisfied subscribers.

Mike Roth is president and owner of Premier Companies, Okemos, Michigan. For more information on Premier's on-hold-message-and-music systems, call 1-800-892-HOLD.

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By Thomas R. Berglund, MD

From our perspective as a medical liability insurer, Michigan Physicians Mutual Liability Company believes tort reforms should improve predictability of losses and reduce premiums in the long term.

The reforms proposed by the Michigan Medical Liability Reform Coalition will accomplish these goals.

Predictability of losses stabilizes rates, and limiting court awards will eventually lower claims costs. The social benefits of lower malpractice rates include better access to obstetrical and other high-risk specialty care and an ability to recruit medical specialists.

Existing tort law creates uncertainty (for example, by allowing unlimited non-economic damages) in an insurer's ability to estimate losses. Consequently, insurers may be forced to maintain higher reserves to prevent insolvency. The result: premiums are pushed upward in order to maintain an adequate financial cushion.

Specifically, here is how tort reforms could improve the Michigan liability environment:

■ **Stabilize rates.** The key element in the proposed legislation is the *absolute* $250,000 cap on non-economic damages. Currently, Michigan has a $280,000 cap (since 1986, adjusted upward for inflation from $225,000), but it's useless with the seven commonly-used exceptions. The seven exceptions are: 1) death, 2) intentional tort, 3) foreign object wrongfully left in body, 4) injury to the reproductive system, 5) fraudulent concealment by provider, 6) wrongful removal of a limb or organ, and 7) loss of vital bodily function.



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Owen Brodie, MD, joined CompHealth's locum tenens medical staff in 1989, after 21 years in private practice. Since then he's worked in temporary assignments in state facilities, filled in for attending physicians, covered for private practitioners across the country.

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An absolute non-economic cap of $250,000 will reduce the number of astronomical payouts. The greatest impact will be felt by hospitals, which serve as the "deep pocket" for the large awards.

Another key cost-control measure upgrades qualifications for expert witnesses. Current Michigan law is too nebulous regarding these requirements.

■ **Reduce rates in long term.** Due to the 'long tail' on medical malpractice claims, cost and rate reductions wouldn't be realized for several years. This sharply contrasts with auto insurance, for example, in which the impact would be immediate. The average claim at Michigan Physicians Mutual takes two years from the incident to be filed and then two years or more to resolve. Therefore, we can expect downward pressure in rates about four years after tort reforms pass.

To artificially lower rates through mandatory reductions – disregarding actual cost reductions – is inappropriate. Cost reductions must precede rate reductions or an insurer's solvency can be jeopardized. With strict reforms, we have estimated rate reductions in the range of 20 percent if the reforms pass legal tests in court.

■ **Provide affordable higher limits.** Most physicians in Michigan are insured at $100,000 or $200,000 limits. In most other states, physicians commonly buy limits of one million dollars or more. Our company offers limits up to one million dollars, and a small but increasing number of insureds are purchasing higher limits. However, many more policyholders would purchase one million dollars coverage if it were more affordable. The tort reform package would undoubtedly make higher coverage limits more affordable, and provide more protection for physicians.

■ **Promote arbitration as an alternative.** We advocate tort reforms that would promote the use of arbitration, which has the potential to reduce claims costs because it reduces legal costs. Resolving claims through the courts is time-consuming and costly. Unfortunately, a negligible portion of medical liability claims are resolved through arbitration, which is viewed by plaintiffs as an obstacle to a lotto-sized award. Last year at Michigan Physicians, fewer than 10 of 1,000 claims were arbitrated.

The end result

The benefits of lowering malpractice costs through tort reform are indisputable: more high-risk specialty services, more specialists would be willing to relocate, hospitals could use money from reduced liability premiums for worthwhile projects, and injured patients would be more quickly and fairly compensated.

Michigan Physicians Mutual strongly supports reforms, and we hope this is the year for changes.

Doctor Berglund is president and chairman of the board of MPMLC.

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MSMS Annual Scientific Meeting

WILL TAKE "NEW DIRECTIONS" TO THE REN CEN

By Ralph Ward



Renaissance Center

Although it's still six months away, the 1993 MSMS Annual Scientific Meeting is already gaining attention for its expanded scope, fresh directions – and new location.

The 128th ASM, "Medicine: Moving in New Directions," is scheduled for November 9, 10 & 11, and will indeed show new directions in the quality of educational programs offered. Although plenary sessions, courses and special events are still being finalized, expect more hands-on programs, classroom demonstrations and original presentations. According to Dorothy M. Kahkonen, MD, Chairman of the ASM Planning Committee, "there's a lot of exciting programming being planned this year. We've already received over 30 course proposals for the meeting. We plan to have more to do, more to see, and more interactive sessions than ever before." The meeting will continue to feature some of the most qualified physicians throughout Michigan, but also will highlight several nationally known physicians discussing the latest in medical technology.

One of the most obvious changes in the meeting will be the new location. "We're delighted about the move to the Westin Hotel in the Renaissance Center," says Joan Stryker, MD, of the Wayne State University School of Medicine. "When a meeting has been in one location as long as the ASM has, it starts to become stagnant and the facility becomes complacent." The Committee no longer felt the meeting was getting the attention it deserved. "We're looking forward to the change and the opportunity to improve upon an already successful meeting," says Doctor Stryker.

The ASM Planning Committee saw a need for change several years ago, and began a thorough study of alternative plans and locations for the meeting. Miriam Daly, MD, of Albion, took part in committee site visits to find a new home

for the ASM. "We looked at Lansing first, because the location is so central in the state," says Doctor Daly. Unfortunately, the city's main convention center will be under remodelling at the time of the ASM this fall, and no other facility in the Capital City was deemed adequate. (Lansing remains a candidate for the 1995 ASM, however.) Few other facilities in Michigan can handle a meeting the size of the ASM, and most were too remote for the MSMS membership. The Committee began seriously considering the Westin Hotel in the Renaissance Center in downtown Detroit as a new location.

The Planning Committee listed overcoming the image of the downtown Detroit area, including safety and parking, as an important issue to consider. "The Committee raised the same concern we've heard from some members, explains Lori Randall, chief of Physician Education for MSMS. But that was before they toured the Westin and saw what it's really like."

Ren Cen a good choice

What the ASM Committee found at the Westin Hotel assured the Committee that it was the right move for the meeting. The 73-story Westin is the keystone of the Renaissance Center Detroit complex. Towering 712 feet above Jefferson Avenue, the Westin is the third tallest hotel in the world. It has been a crucial part of national events such as the 1980 Republican Convention and Super Bowl XVI. It is the headquarter hotel for the Detroit Grand Prix. With 1,400 rooms (including 65 suites), six food and beverage facilities, 30 meeting rooms, and a 25,000-square-foot exhibit hall, it is one of the few facilities in the state able to fully accommodate the Annual Scientific Meeting under one roof.

The ASM Planning Committee found other attractions at the Westin. The Westin's Ontario Exhibit Hall offers more room than in previous years, and will allow the popular combination of exhibits and dining in the same area. The layout will allow all meetings, special events and Specialty Society functions to be held in the convenient center tower of the Renaissance Center. A full-service health club, jogging track and swimming pool are located within the complex. More than 80 first-class shops, four theaters, and 23 eating establishments are conveniently located on two levels of the four connecting towers. The 71st floor of the hotel tower features "The Summit," a revolving restaurant offering fine dining and a stunning panoramic view of the Detroit and Windsor area.

Doctor Kahkonen: "The Committee is convinced that the Westin Hotel and Renaissance Center offer excellent convenience, security, and parking for our members." All the overnight rooms have been recently remodeled, and additional signage has been added to make the meeting rooms easy to find.

Secure valet and self-parking for up to 4,200 cars is available in or near the complex. Valet parking will be included in the cost of overnight rooms for ASM participants. In addition, special arrangements are being made to include free, reserved parking for all participants. Passes on Detroit's People Mover transportation system also will be available, putting most downtown attractions within easy proximity of the meeting.

Some of the local attractions on the People Mover route are among the most famous in Michigan, including the Trappers Alley Marketplace in Greektown just north of the Renaissance Center; Bricktown, with its turn-

Continued on following page

Trapper's Alley



Fox Theatre



Continued from page 47

of-the century shops and restaurants, and the recently revitalized theatre district which includes the Fox, State and Gem theaters. The Detroit Institute of Arts, the Detroit Science Center and Rivertown, the renovated warehouse shopping area east of the Renaissance Center are just a short drive away.

Education is the key

While the new location adds to the excitement and convenience, the real point of the ASM is to offer Michigan physicians new information and perspectives to improve patient care, and this year's meeting should not disappoint anyone. Balance is sought between the day's courses, topics and fields of practice. Traditionally, the three-day conference offers more than 50 separate educational courses approved for Category I CME and family physician prescribed credits. This year the program will also be submitted for osteopathic credits. "We try to include updates on the latest in medicine," says Doctor Daly. "Differing interests are met with a balance between primary care and specialty courses." A source of particular pride to Doctor Stryker is the coordination between the state's three medical schools, the Michigan State University College of Human Medicine, the University of Michigan Medical School and the Wayne State University School of Medicine. "Good heavens, where can you find such expertise anywhere else," exclaims Doctor Stryker.

Comments from previous attendees have encouraged the Committee to maintain this balance of programming. Special attention will be given to bringing in even more nationally-acclaimed speakers to present the plenary sessions and related courses. The early-morning plenary sessions are available free of charge to all MSMS members. In addition, some half-day programs will be featured as "visiting lectureships," featuring out-of-state speakers who many physicians don't get a chance to hear in their area.

Speakers for the 1993 ASM are yet to be finalized, but the committee members promise speakers who will be topical, enlightening and informed. "We try to have speakers who can give us up-to-date information on current health problems," says Doctor Daly. "This year we hope to have someone who can also discuss upcoming changes in government health care plans."

Also look for an expanded exhibit hall selection, including more than 90 health care displays. Free practice management consulting services will include attorneys, advisors and consultants to answer specific questions in small group discussions or private sessions. A new feature this year will be a display depicting the medical office of the future, a totally new exhibit hall layout, and a "food court" style eatery in the exhibit hall. Admission to the exhibit hall is free for all Michigan physicians and their medical office staff.

Auxiliary programs planned

Special auxiliary programming is being organized during the ASM. In addition to special activities to enjoy the local attractions, quality educational programming on the medical marriage and leadership skills will be included. Educational sessions for medical office staff and medical group managers also are being planned in conjunction with the meeting.

The new location, new scope, and new opportunities will combine to make the 1993 Annual Scientific Meeting the most enriching and enjoyable in the event's 128-year history. Notes Doctor Stryker: "For the cost involved and the CME's available, the ASM is like they say in T.J. Max ads, *the maximum for the minimum."*

Ralph Ward is a Lansing-based freelance writer.

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November 9, 10 & 11, 1993

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MEETINGS

MSMS Meetings

April

7, 8, 14, 15, MSMS/MPMLC Risk Management: Closed Claim Reviews (Psychiatry).

7, Treasure Island, Saginaw. April 8, Novi Hilton, Novi. April 14, WMU Regional Center, Grand Rapids. April 15, MSMS Headquarters, East Lansing. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

8, MSMS CME Accreditation Conference, Michigan Athletic Club, East Lansing. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

12-13, MSMS Practice Management Seminar, "Medical Biller Training Series (Medicare)," Novi Hilton, Novi. Contact: MSMS Office of Physician Education, (517) 336-5784.

13, MSMS Program, "Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide," Radisson On The Lake, Ypsilanti. Contact: Helen Fordham, MSMS Communications, (517) 336-5786.

15, MSMS Opportunities 1993: An Array of Medical Practice Opportunities for Michigan Physicians, Detroit. Contact: MSMS Office of Physician Education, (517) 336-5784.

15, MSMS Professional Well-Being Workshop, Holiday Inn, Flint. Contact: Sherry Fent, MSMS Office of Physician Education, (517) 336-5784.

19, 20, 21, MSMS Practice Management Seminar, "How to Comply with CLIA Regulations." April 19, Holiday Inn, Flint. April 20, Wayne County Medical Society, Detroit. April 21, Fetzer Center, Kalamazoo. Contact: MSMS Office of Physician Education, (517) 336-5784.

20, 21, 22, MSMS Supervisory Skills Series - Part II (How to Deal With Difficult People and Situations). April 20, Holiday Inn, Flint. April 21, Michigan Athletic Club, East Lansing. April 22, Hotel Baronette, Novi. Contact: MSMS Office of Physician Education, (517) 336-5784.

20, 21, 22, 27, MSMS/MPMLC Risk Management: Closed Claim Reviews (Pathology). April 20, Sylvan Resort, Gaylord. April 21, Treasure Island, Saginaw. April 22, Novi Hilton, Novi. April 27, MSMS Headquarters, East Lansing. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

27, 28, MSMS Coding Clinics for Specialties. April 27, WMU Regional Center, Grand Rapids (Radiology/Primary Care). April 28, Holiday Inn, Flint (Radiology/Primary Care). Contact: MSMS Office of Physician Education, (517) 336-5784.

29, MSMS Future Vision: Physicians in the Year 2002, Ritz Carlton, Dearborn. Contact: MSMS Office of Physician Education, (517) 336-5784.

30, MSMS Board Meeting, Michigan State Medical Society, East Lansing. Contact: William Madigan, MSMS Executive Director, (517) 336-5784.

30 - May 2, MSMS House of Delegates, Ritz Carlton, Dearborn. Contact: Donna Farougi, Coordinator, Special Programs, (517) 336-5735.

May

2, MSMS Board Meeting, Ritz Carlton, Dearborn. Contact: William Madigan, MSMS Executive Director, (517) 336-5734.

July

14-18, MSMS Midsummer Board Meeting, Shanty Creek, Bellaire. Contact: William Madigan, MSMS Executive Director, (517) 336-5734.

November

9-11, MSMS Annual Scientific Meeting, Westin Hotel, Detroit. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

Michigan Specialty Society Meetings

August

14-20, The Twelfth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine. Contact: Society of Magnetic Resonance in Medicine, Inc., (510) 841-1899.

AMA Meetings

June

10-17, AMA House of Delegates, Chicago, IL. Contact: Judy Marr, MSMS Manager, Department of Communications and Professional Relations, (517) 337-1351.

National Specialty Society Meetings

May

20-22, American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

October

13-17, American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

29-31, American Society of Bariatric Physicians, Westin Hotel, Chicago, Ill. Contact: (303) 779-4833.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

April

13, Effective Compassion for the Incurably Ill. Location: Fetzer Center, Kalamazoo, Michigan. **Sponsor:** Michigan State Medical Society, Committee on Bioethics. **Contact:** Helen Fordham, MSMS Committee on Bioethics, (517) 336-5786. **Approved for:** 6 hours Category I Credit.

14-16, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400.

16-17, Sclerotherapy/Peripheral Vascular Evaluation. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 11.5 hours of Category I Credit.

19, 20, 21, How to Comply with CLIA Regulations. Location: April 19, Holiday Inn, Flint. April 20, Wayne County Medical Society, Detroit. April 21, Fetzer Center, Kalamazoo. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Tom Wolff, MSMS Regulatory Ombudsman, (517) 336-5740. **Approved for:** 3.5 hours Category I Credit.

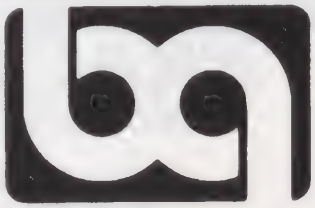
20, Advanced Pain and Symptom Management. Location: Holiday Inn Crowne Plaza, Grand Rapids, Michigan. **Sponsor:** Michigan Hospice Organization. **Contact:** Sue Wierengo, (616) 722-2257. **Approved for:** 3.5 hours Category I Credit.

22 & 23, Medicolegal Investigations of Death. Location: Holiday Inn Fairlane, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Pathology. **Contact:** Division of Continuing Medial Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 14 hours Category I Credit.

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CATEGORY I COURSES

Continued from page 53

23-24, Contraceptive Update/No Scalpel Vasectomy. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 15 hours Category I Credit.

23-24, Advanced Trauma Life Support, Instructor Course. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons and University of Michigan Medical School. **Contact:** Steve Cruise, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

24, Midwest Neuro-Fibromatosis Symposium. Location: Weber's Inn, Ann Arbor. **Sponsor:** Michigan Chapter, NF Foundation, Inc., and the Divisions of Pediatric Genetics & Molecular Medicine & Genetics, University of Michigan Medical Center. **Contact:** Michigan Chapter, NF Foundation, Inc., at (313) 351-4350. **Approved for:**

25, Leep/Letz/Loop. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator 4909 Hedgewood Dr., Midland, MI 48640, 1-800-462-2492. **Approved for:** 5.75 hours Category I Credit.

26-30, Advances in Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Marie McKnight, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 33 hours Category I Credit.

May

11, 2, 13, How To Comply with CLIA Regulations. Location: May 11, Holiday Inn Crown Plaza, Grand Rapids. May 12, Grand Traverse Resort, Traverse City. May 13, Holiday Inn, Marquette. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Tom Wolff, MSMS Regulatory Ombudsman, (517) 336-5740. **Approved for:** 3.5 hours Category I Credit.

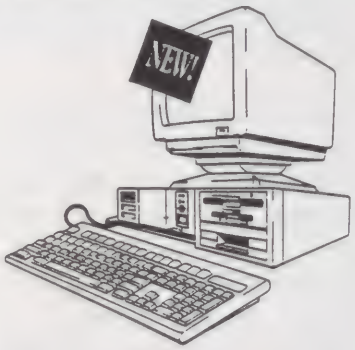
13, Flexible Sigmoidoscopy/Hemorrhoids. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, (800) 462-2492. **Approved for:** 7.5 hours of Category I Credit.

13-14, Vestibular Rehabilitation. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O.

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CATEGORY I COURSES

Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

14-15, EGD (Gastroscopy). Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI, 48640, (800) 462-2492. **Approved for:** 12 hours Category I Credit.

17-22, All Michigan OB/GYN Review Course. Location: Radisson On The Lake, Ypsilanti, Michigan. **Sponsor:** Wayne State University School of Medicine, Wayne State University, University of Michigan and Michigan State University. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 37 hours Category I Credit.

21-22, Current Concepts in Pediatric Opthalmology and Strabismus. Location: W.K. Kellogg Eye Center, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 12.5 hours Category I Credit.

June

1, 2, Diagosis and Management of Breast Cancer. Location: June 1, Novi Hilton, Novi. June 2, WMU Regional Center, Grand Rapids. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

3-4, Current Topics in Blood Banking 20th Annual Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medial School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

4-5, Phonosurgery - Indications and Techniques. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

7-10, 6th Annual Summer Conference on Aging. Location: Novi Hilton, Novi, Michigan. **Sponsor:** Wayne State University School of Medicine, Institute of Gerontology. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180.

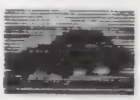
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Continued from page 55

9-11, 11th Annual Laboratory Information System Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 17 hours Category I Credit.

21-25, 29th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Contact: Marie McNight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400.

July

11-13, 7th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort Village, Grand Traverse Resort, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 15 hours Category I Credit.

29-30, 73rd Annual Coiller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, Michigan. **Sponsor:** Munson Medical Center and Medical Staff. **Contact:** Elaine Gaines, Medical Education, Munson Medical Center, 1105 Sixth St., Traverse City, MI 49684-2386, (616) 935-6546.

August

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. **Contact:** Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 60 hours Category I Credit.

September

15, Diagnosis and Management of Myocardial Infarction. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

22, 23, Diagnosis and Management of Myocardial Infarction. Location: September 22, Novi Hilton, Novi. September 23, WMU Regional Center, Grand Rapids. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

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CME SESSION

9:00 A.M. - 12:15 P.M.

Eli Brown, M.D., Chair
Dept. of Anesthesiology
WSU School of Medicine
Overview of Training and Management of a Pain Clinic

John Dooley, Ph.D.
Dir., Gertrude Levin Pain Clinic
Detroit Medical Center
Asst. Prof. F.T.A. Psychiatry
WSU School of Medicine
Psychological Aspects of Pain

Laurence Baker, D.O.
Asst. Dean for Cancer Programs
Div. of Hematology and Oncology
WSU School of Medicine
Pain Associated with Malignancies

Michael Mulroy, M.D.
Staff Anesthesiologist
Virginia Mason Medical Center
Seattle, WA
Management of Acute Pain

Robert H. Fitzgerald, M.D., Chair
Dept. of Orthopedic Surgery
WSU School of Medicine
Management of Musculoskeletal Pain

12:30 P.M.

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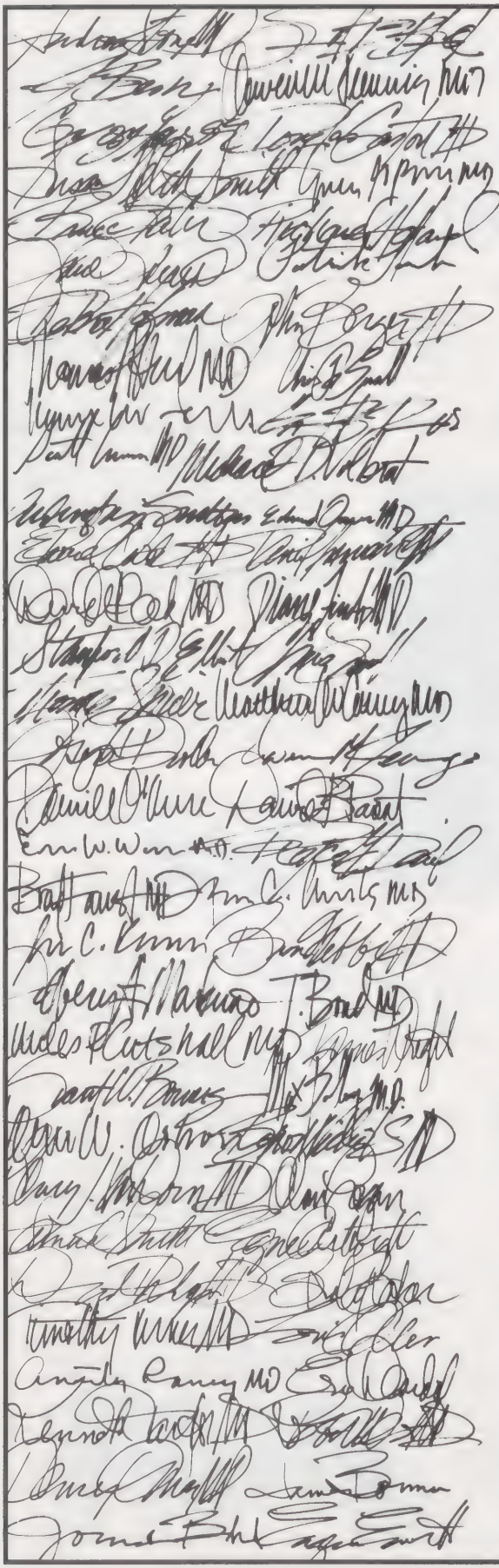
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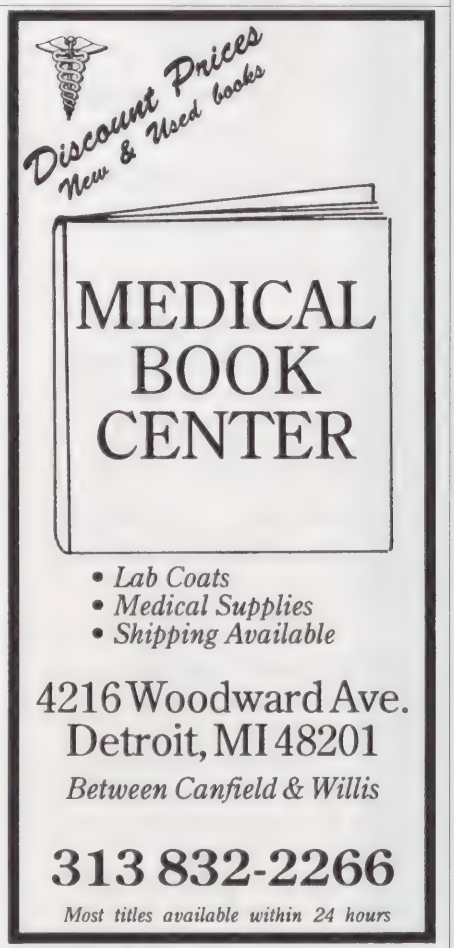
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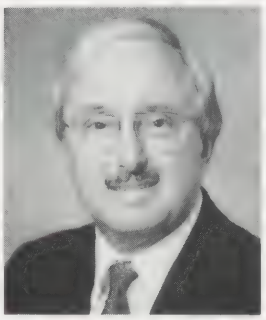
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PRESIDENT'S PAGE

Domestic Violence

Much more needs to be done

By Thomas C. Payne, MD



In my final President's Page I'd like to write about a topic that we physicians can do something about right now. It will affect all the people in the state of Michigan. The topic is domestic violence.

As the cornerstone of my presidential year, I announced last May a program to address domestic violence. Our accomplishments to date have been many, but much more needs to be done. Because of the magnitude of this project, MSMS has decided to form a permanent task force.

To begin, we convened 40 to 50 groups interested in the problem. We call the group the MSMS Forum on Domestic Violence. We have representation from all the various players involved in this problem which include physicians, nurses, social services, law enforcement, judiciary, attorneys, counselors, shelters, and public health. The forum participants have divided into five subgroups. I will briefly discuss what each has done and plans to do.

Physician Education

■ We devoted a *Michigan Medicine* cover story to domestic violence.

■ We offered courses at the MSMS Annual Scientific Meeting on domestic, child and elder abuse, and will offer courses, again, at the 1993 Annual Scientific Meeting.

■ We will publish by the end of the year a complete reference book similar to one developed by the Ohio State Medical Association.

Public Education

■ We are planning a public education campaign to let people know their rights and what to do if they become a victim.

Hospital-Based Efforts

■ We are helped by a recent JCAHO requirement that hospitals have protocols for dealing with domestic violence.

■ We have surveyed all Michigan hospitals on their services to victims of abuse and now serve as a resource to enable cases to be handled more efficiently.

■ We will present a conference in the fall to assist hospitals in establishing programs to meet the JCAHO requirements.

Legislation

■ We have reviewed pending legislation and are proposing support of the most effective bills by the groups represented in the forum.

Legal Ramifications

■ We propose developing seminars to help physicians understand how better to work with the legal system and to identify services to solve these problems.

Much has been accomplished, but much more needs to be done. Please join us in this crucial endeavor.

A farewell thought

Since this is my last column, I wanted to thank all of you who have hosted me in my travels around the state from Watervliet to Petoskey to Marquette to Adrian and many points in between. I appreciate your support and what you do to better the health of Michigan residents.

I also want to thank the staff of MSMS for the timely support, be it furnishing reports, driving me to meetings or keeping me up-to-date on the status of legislative activity. I am proud of all MSMS staff members and you should be, too, because their contributions are many.

It has been an honor to serve as your president. I will always cherish the privilege to serve our 11,500 members and I hope my legacy of *P*articipation, *R*epresentation, *I*nvolvement, *D*edication and *E*nvironment - spills off to other members in the Society as the PRIDE which I feel for the privilege of being a physician and a member of MSMS.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid, or probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/– mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitounnary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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Results of the MSMS Survey on Practice Characteristics

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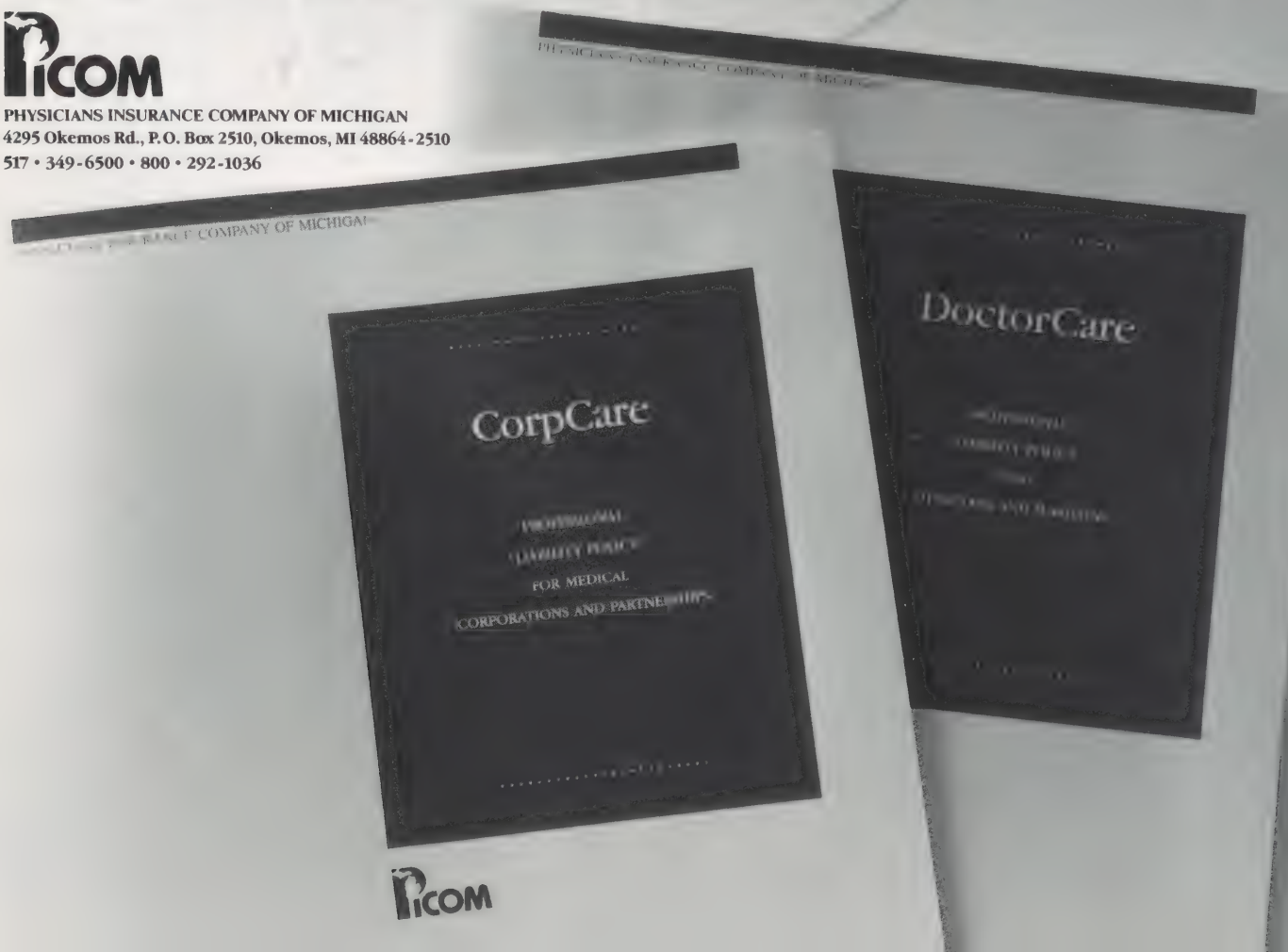
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Michigan Medicine (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published once each month, 12 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $100.00 (includes weekly *Medigram* newsletter); single copies, $3.00: Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news and exchanges should be addressed to Betty McNerney, advertising to Pat Horan, and address changes to Kathy Hagen, Michigan State Medical Society, P.O. Box 950, East Lansing, Michigan 48826-0950. Phone 517-337-1351.

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MAY 1993 VOLUME 92, NO. 5

Award-Winning Journal of the Michigan State Medical Society



MSMS SURVEY ON PRACTICE CHARACTERISTICS

There is no doubt among Michigan physicians that information, and the effective use of that information, equals power. MSMS members, through the 1992 House of Delegates, requested that MSMS develop more specific data about the practice of medicine in Michigan – data that would not only help physicians measure their own performance, but also data that could be used for public relations and advocacy efforts.

In response to that request, MSMS recently conducted a comprehensive member survey which asked questions about these topics: demographics, practice arrangement, staffing and resources, practice environment, community/environment, hours and services, liability, third party payers and finance.

With the responses now tabulated, MSMS is pleased to present the complete results of the MSMS Survey on Practice Characteristics in this special issue of *Michigan Medicine.*

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Cover Design: *By Stephen M. Amor, Abbott Press, Inc.*

MSMS MD data

RESULTS OF THE MSMS SURVEY ON PRACTICE CHARACTERISTICS

EXECUTIVE SUMMARY

By Julie L. Lester, MHSA
MSMS Chief of Health Care Research

"Only by knowing the facts about ourselves will we be able to educate others about the medical practice environment in Michigan."
—Thomas C. Payne, MD
MSMS Immediate Past President

"For MSMS leaders to accurately reflect the position of physicians in society, reliable factual data is required. Many adversaries of physicians make comments based on information that is not germane to Michigan. If we collect reliable data we can refute these erroneous claims and advance new causes."
—Fred E. Patterson, MD
MSMS Board of Directors

There is no doubt among Michigan physicians that information, and the effective use of that information, equals power, as the accompanying quotes suggest. MSMS members, through the 1992 House of Delegates, requested that MSMS develop more specific data about the practice of medicine in Michigan -- data that would not only help physicians measure their own performance, but also could be used for public relations and advocacy efforts.

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Surveys were mailed to all active members in October 1992. A total of 1,846 completed surveys were received, for a statistically-valid response rate of 22.1 percent.

With the responses now tabulated, MSMS is pleased to present the complete results of the MSMS Survey on Practice Characteristics in this special issue of *Michigan Medicine*. Information gathered from this comprehensive survey will be used in a variety of ways to promote the interests of all physicians and patients. MSMS will use the data in legislative testimony, press releases and public information campaigns. Individual physicians are encouraged to use the information locally.

In addition to this special report, MSMS will continue to distribute to members its bimonthly newsletter, *MSMS MD Data*. This newsletter, which features data and information for physician leaders, was launched in December 1992.

Following are some of the key findings of the MSMS Survey on Practice Characteristics.

Demographics

- Respondents ranged from 30 to 82 years of age, with an average age of 49.5 years.
- 81 percent of respondents practice in urban areas and 19 percent practice in rural areas.
- 35 percent consider themselves primary care physicians and 65 percent consider themselves specialists or consultants.
- 51 percent trained at Michigan medical schools, 29 percent at other U.S. schools, and 19 percent at international medical schools.
- 88 percent are board certified.
- 96 percent of physicians are registered to vote.

Practice Arrangement

- 52 percent of respondents are in group practice, with a median group size of five physicians. A total of 81 percent of the groups are single specialty and 19 percent are multiple specialties.

Staffing and Resources

- 30 percent of respondents submit paper claims to third party payers.
- 85 percent of offices have a computer. Of those which do not, the primary reason for not having one is the expense of purchasing and maintaining it.

Practice Environment

- 69 percent of respondents say their professional satisfaction has decreased as a result of the changes in the practice of medicine, 67 percent say their personal satisfaction has decreased, and 48 percent say their emotional health has decreased.
- 43 percent strongly agree that they will retire before age 65 and another 18 percent somewhat agree. The primary factors influencing the decision to retire early are fear of litigation and government regulation.
- 26 percent say there are too few physicians in their specialty and area, 19 percent say there are too many, and 50 percent say there is about the right number. Primary care and rural physicians were the most likely to say there are too few physicians.

Community/Environment

- AIDS, substance abuse and cancer are the health problems physicians have seen increase in their practice in the last five years.
- Physicians are getting more questions from patients on screening procedures and diet or nutrition than five years ago.
- Water quality, concerns about landfills and medical waste disposal are the biggest environmental problems physicians face in their communities.

Hours and Services

- Respondents work an average of 61.5 hours per week. In the month prior to the survey, 82 percent of physicians were on call for an average of 183 hours a month.
- 51 percent of physicians have limited the number or types of services they provide in the last five years. The primary reasons for limiting services are fear of litigation and malpractice premiums.
- 66 percent of respondents provided charity care in the week prior to the survey. The average physician gave 3.5 hours of free care and 3.9 hours of reduced fee care in that week. A total of 40 percent of physicians say the amount of charity care they give has increased in the last five years.

Liability

- Nearly one-half of respondents have $200,000/$600,000 professional liability coverage.
- 61 percent of physicians surveyed have had a liability suit brought against them in their career. The average number of cases brought is 2.7.

Third Party Payers

- 74 percent of respondents formally participate with Medicare and another 17 percent accept assignment on a per case basis. Nearly one-half of physicians say their reimbursement has decreased under the Resource Based Relative Value System (RBRVS). Almost all physicians say they will continue seeing Medicare patients.
- 67 percent of physicians have signed the Blue Cross Blue Shield of Michigan (BCBSM) contract, and another 18 percent accept assignment on a per case basis.
- One-half of physicians accept Medicaid patients without limitations, and another one-third accept a limited number of Medicaid patients. The primary reason for limiting or not seeing Medicaid patients is reimbursement.
- Two-thirds of physicians had contracts with HMOs, PPOs, or IPAs in 1992. Forty percent say they have regretted affiliating with a managed care plan.
- 60 percent of physicians have been prevented from providing a medically necessary service because an insurer would not pay for it.
- 63 percent say that financial incentives and limitations in reimbursement plans affect their ability to exercise medical judgment.

Financial

- The average gross revenue per physician is $343,600. The average for total professional expenses is $191,800. The average for net income is $161,000, with a median of $140,000.

Have questions about the survey? Just call Julie Lester at MSMS (517) 336-5768.

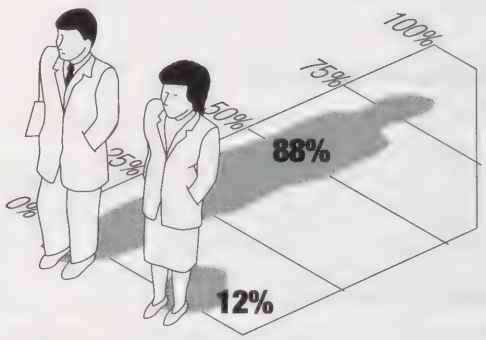


MSMS MD data

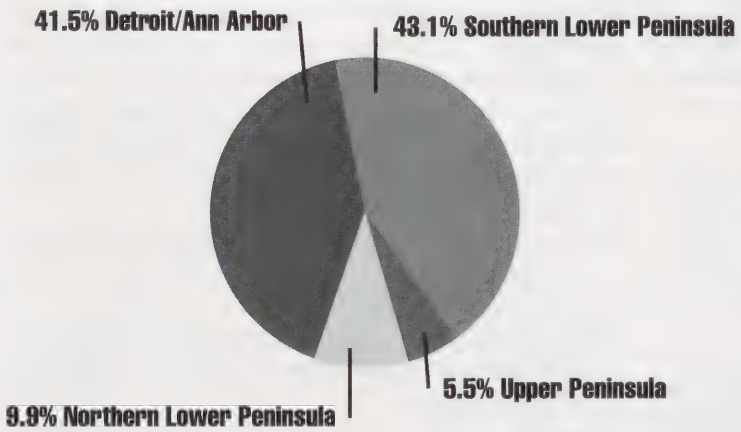
DEMOGRAPHICS

The survey sample is 88% male and 12% female. Eighty-one percent practice in urban areas. The age of respondents ranges from the youngest at 30 to the oldest at 72. The average age is 49.5. The average respondent has been in practice for 18 years. Nearly two-thirds of the sample describe themselves as specialists or consultants, while the other third consider themselves primary care physicians. A larger proportion of urban physicians are specialists, whereas the rural physicians are evenly divided. Over one-half of respondents are from Michigan medical schools; this is consistent in three of the regions, except for the Upper Peninsula where graduates from other states are more common. The vast majority of physicians are board certified and are registered to vote.

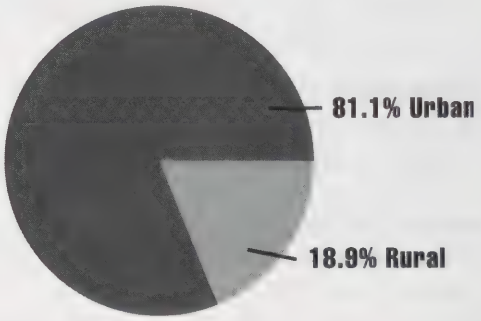
Gender



Respondents by Region

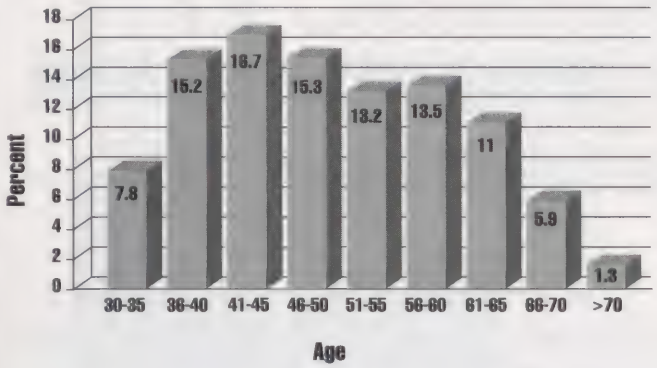


Urban vs. Rural Respondents

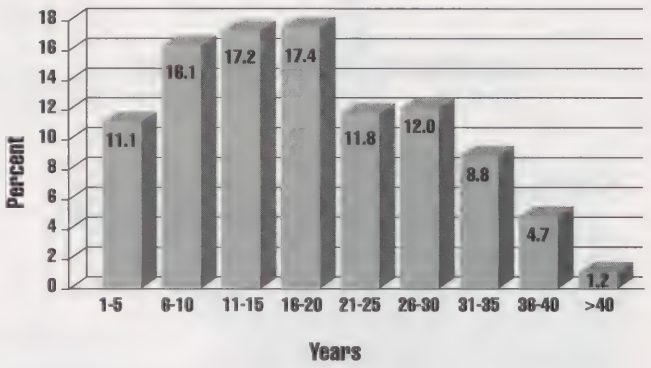


DEMOGRAPHICS *continued*

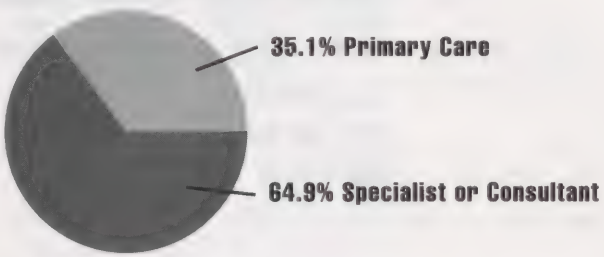
Distribution by Age



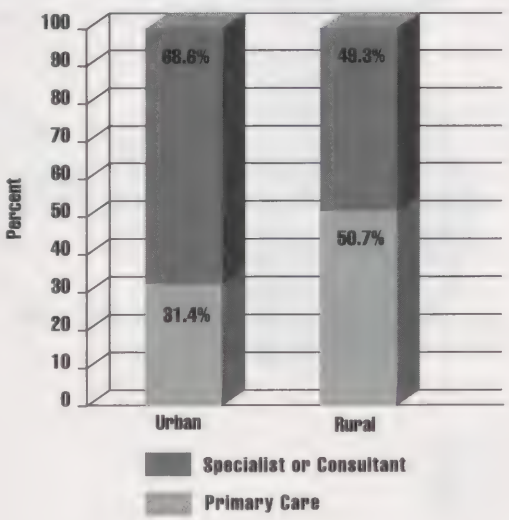
Years in Practice



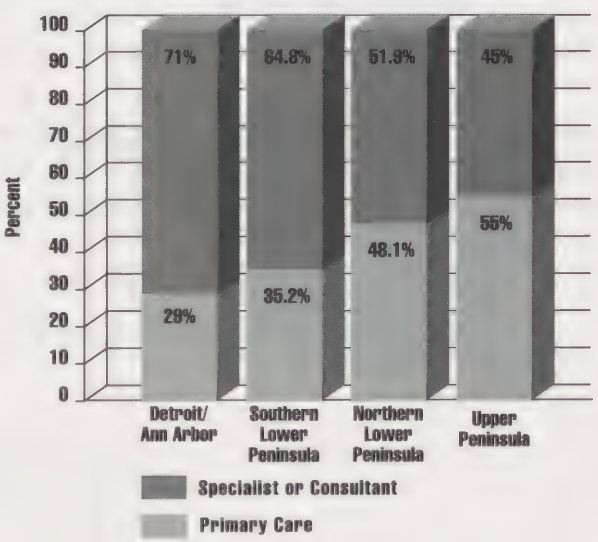
Focus of Practice



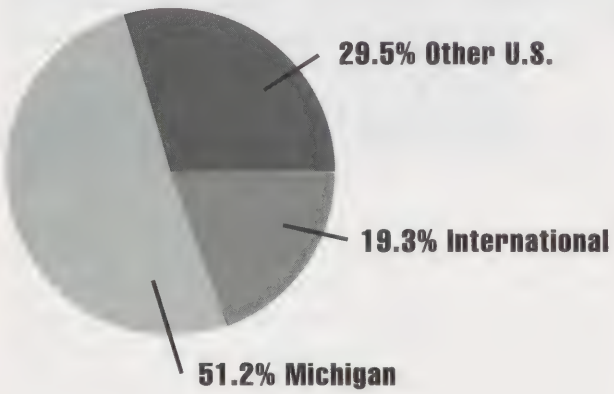
Focus of Practice by Location



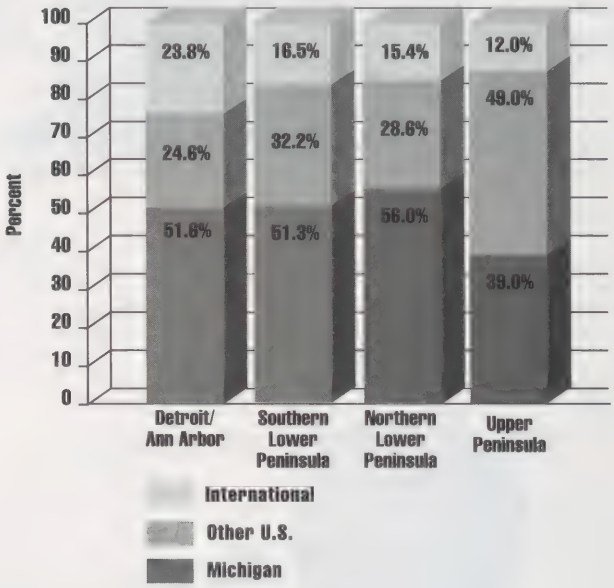
Focus of Practice by Region



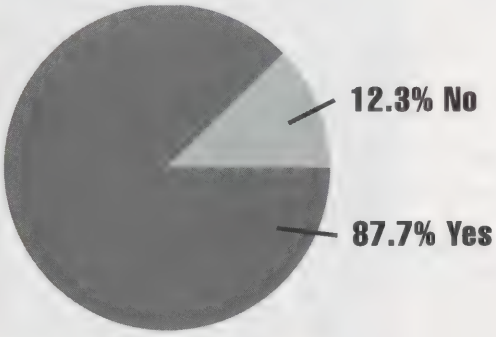
Location of Medical School



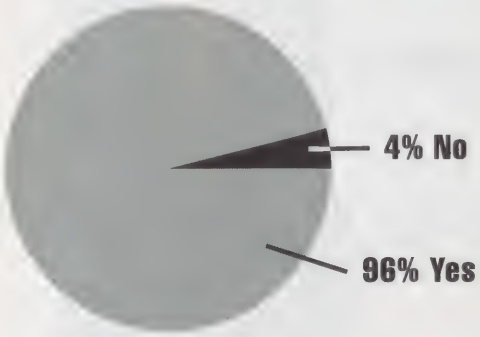
Location of Medical School by Region



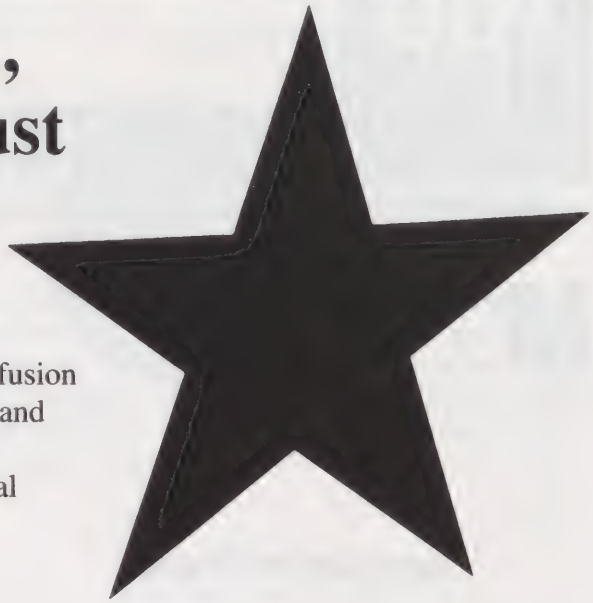
Board Certified



Percentage of Physicians Registered to Vote



Compared With Critical Care America's STAR Commitment, Everything Else Is Just A Leap Of Faith



Critical Care America, an innovative leader in home infusion therapy, is dedicated to providing superior quality care and support to patients in their homes. Our reputation for responsiveness to our customers needs has made Critical Care America a leader in home infusion therapy.

The S.T.A.R. (Specially Tailored Action and Results) Commitment carries our guarantee that we will listen to you, work with you and provide you with:

- ★ realistic, workable solutions to meet your home care patient challenges;
- ★ streamlined processes to make your experience with Critical Care America simpler and more efficient;
- ★ innovative, creative options that enhance your ability to successfully manage the needs of home infusion patients; and,
- ★ tangible results that ensure your ultimate satisfaction with Critical Care America's services.

Critical Care America recognizes your needs, and has the resources and commitment to quickly respond to them. We are committed to developing programs that give you exactly what you need, when you need it. And will then back that commitment in writing.

So before you leap into an arrangement with any other home infusion therapy provider, find out more about our STAR Commitment and how it will benefit you. Just call your local Michigan Critical Care America representative to get things started. We know you will be satisfied with our actions—and the results.

Responsiveness Is Where We Shine™ ★

Critical Care
AMERICA

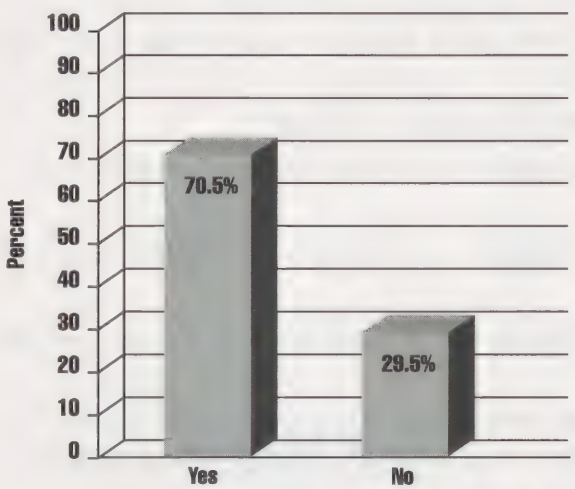
1000 North Opdyke Road, Suite F ★ Auburn Hills, MI 48326
313-373-3131 ★ 800-333-2133

MSMS MD data

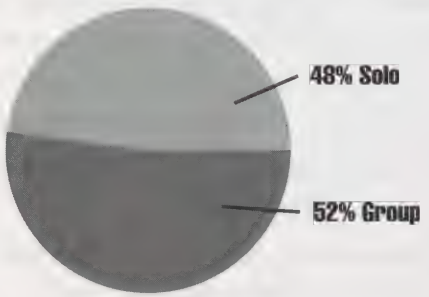
PRACTICE ARRANGEMENT

More than two-thirds of physicians in the survey are in an incorporated practice, and slightly more than half are in a group practice. The median group size is five physicians. The vast majority of physicians (81%) are in single specialty groups. Multi-specialty groups are more common in rural areas (40.5%) than they are in urban areas (13.7%). When asked whether they had changed the organizational arrangement since entering medical practice, 62% said they had not. Of those who had made a change the most common change was from solo to group practice, although a similar proportion had gone from group to solo practice.

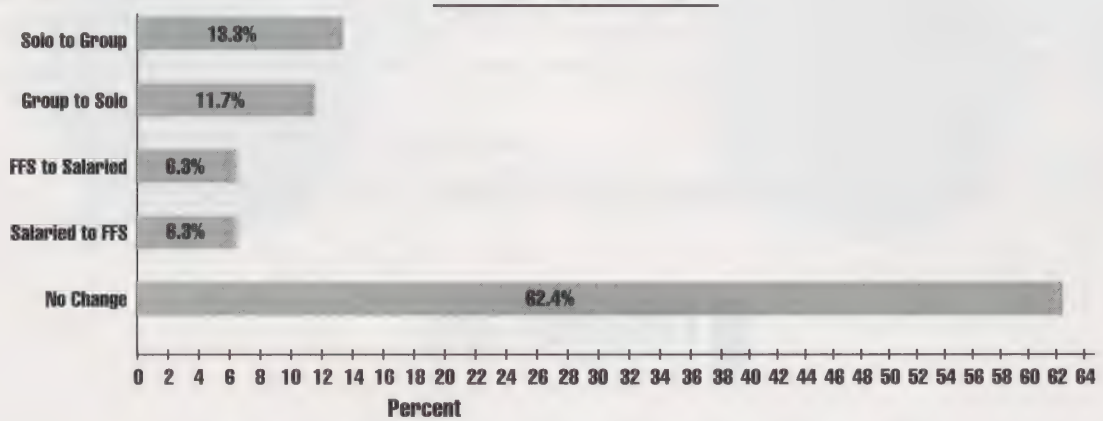
Incorporated Practice



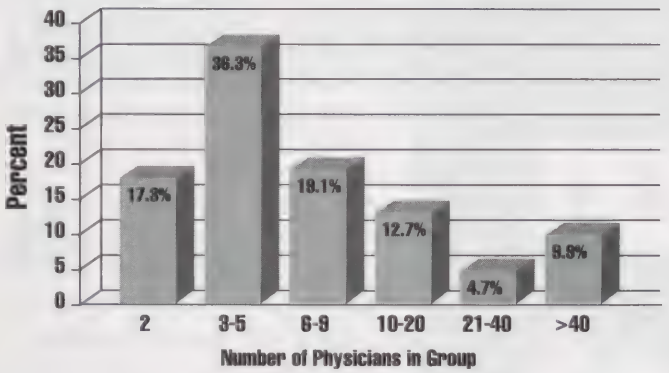
Type of Practice



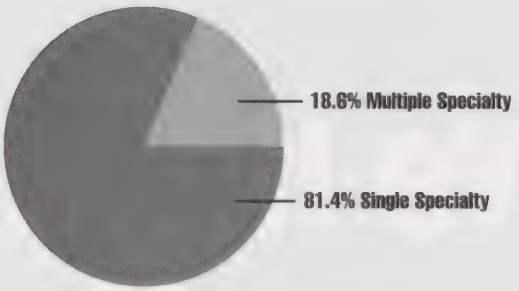
Change in Practice



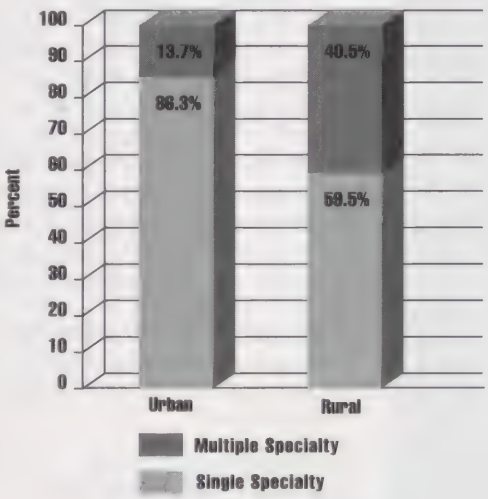
Size of Physician Groups



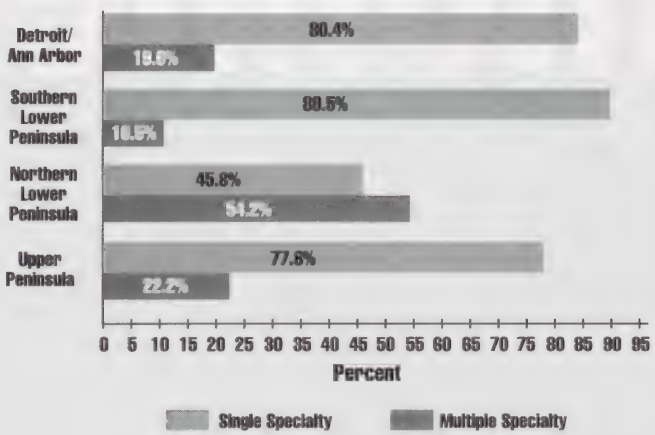
Type of Group



Type of Group by Location



Type of Group by Region



We have an excellent bedside manner.

Unlimited on-site training
After hours support.
24-Hour emergency pager.

We strive to cure your computer ills with compassion!
Our staff is made up of folks who have worked in physician's offices. We know what you are going through! That's why we offer the services we do. . . our experience shows that these services help make the automation or conversion process easier for both you and your staff!

The only silly question is the one that isn't asked.
We answer questions about the system, of course, but we also have consultants who can assist you with any type of question you may have about your practice; billing, collections, office efficiency, marketing, etc.

This kind of service doesn't disappear after 60 or 90 days.
Training for the original staff and telephone support is ALWAYS free.

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24 hours a day, 7 days a week, technicians and trainers are available via an Emergency Pager.

But what about the product?
The Medical Manager® has been chosen by over 50,000 health care professionals to manage the business end of their practice. Powerful features handle accounts receivable, insurance billing, appointment scheduling, clinical history, recalls, referring doctor information, hospital rounds, and procedure and diagnosis histories.

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For more information, call us at 1-800-968-7518 or (313) 939-5900.

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"Success Built on Superior Service."

Endorsed by the Wayne County Medical Society Service Bureau

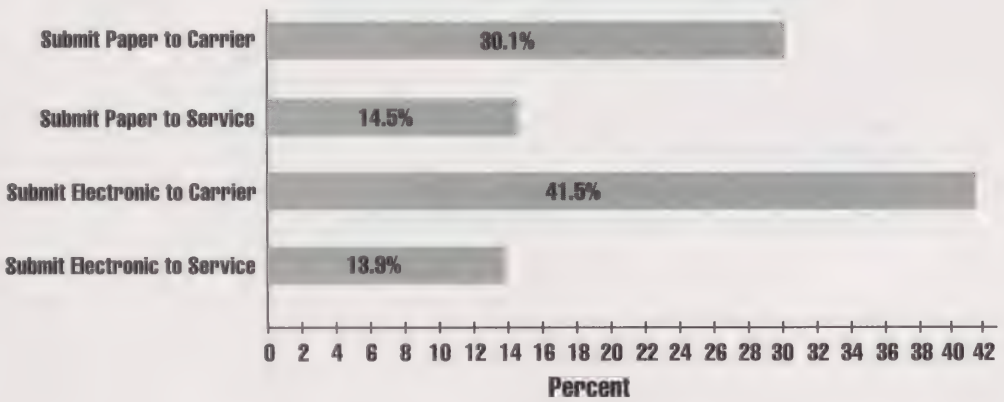
MSMS MD data

STAFFING AND RESOURCES

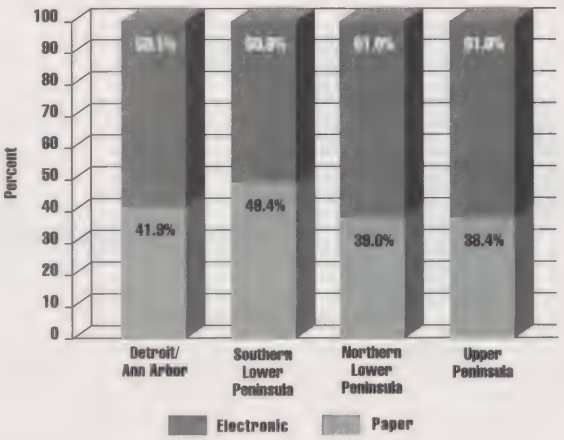
Respondents are evenly divided between paper and electronic claim submission to third party payers. The largest proportion submit electronic claims directly to the carrier (41.5%), while another 30% submit paper claims. An equal proportion submit either paper or electronic claims to a billing service, which then forwards electronic claims to the carrier. In all, 70% of respondents submit claims that ultimately arrive at the carrier electronically.

Only 15% of respondents do not have a computer in their office, with the expense of purchasing and maintaining a system being the primary barrier. Almost 30% of respondents stated that they do not have a computer because they are planning to retire soon. Cited as often as retirement was a need for more information about choosing a system and insufficiently trained staff. Of those who did not own a computer, 28% plan on purchasing one in the next two years, but 46% do not.

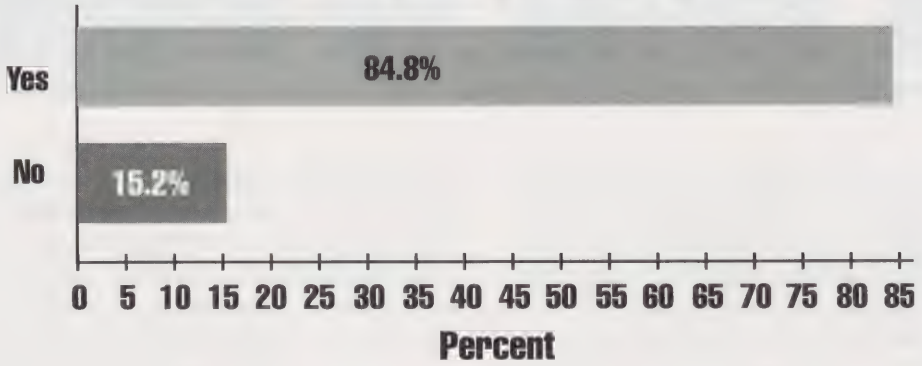
Primary Method of Submitting Claims



Method of Submitting Claims by Region



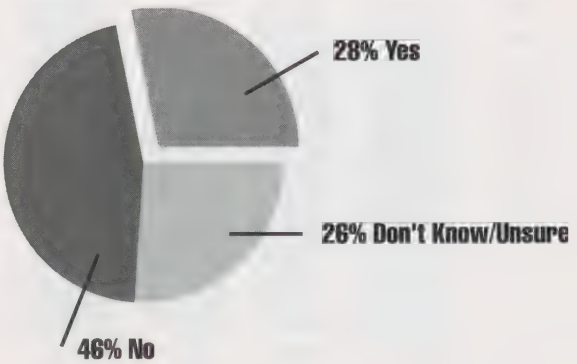
Office Uses a Computer



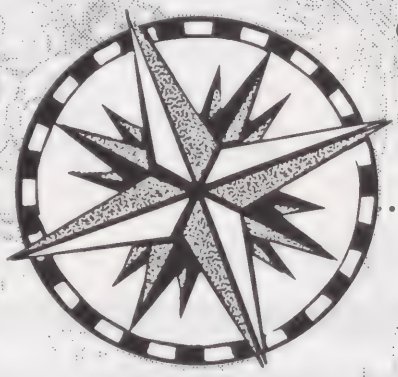
Reason for Not Having a Computer

Expense of purchasing/maintaining	56.7%
Planning to retire soon	29.5%
Need more knowledge about choosing one	28.7%
Insufficiently trained staff	28.0%
Too few claims for carriers that accept electronic	20.1%
Too many claims that require hard copy submission	6.0%

Computerize in Two Years



MEDICINE



MOVING
IN
NEW
DIRECTIONS

Michigan State Medical Society

1993 ANNUAL SCIENTIFIC MEETING

November 9, 10 & 11, 1993

Westin Hotel, Renaissance Center, Detroit

MSMS MD data

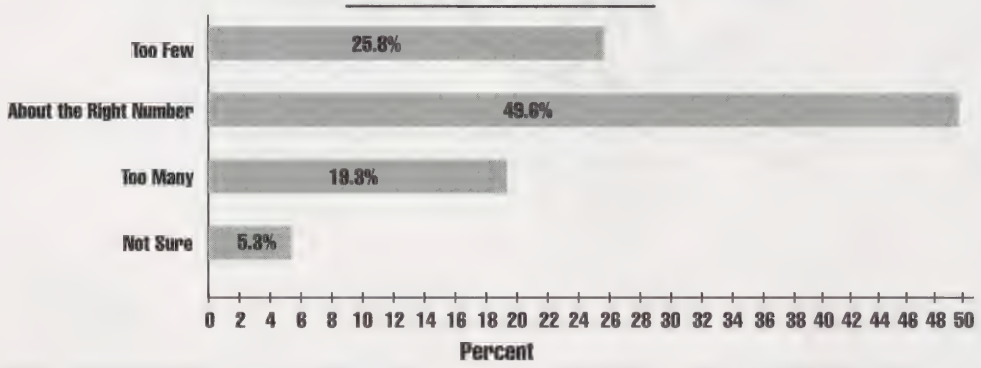
PRACTICE ENVIRONMENT

When asked about the supply of physicians in their area and specialty, nearly half said there was about the right number. Twenty-six percent felt there were too few and 19% said there were too many. Rural physicians and primary care physicians were twice as likely to say there were too few physicians, whereas urban physicians and specialists were twice as likely to say there were too many. Around half of Northern and Upper Peninsula physicians said there were too few in those areas.

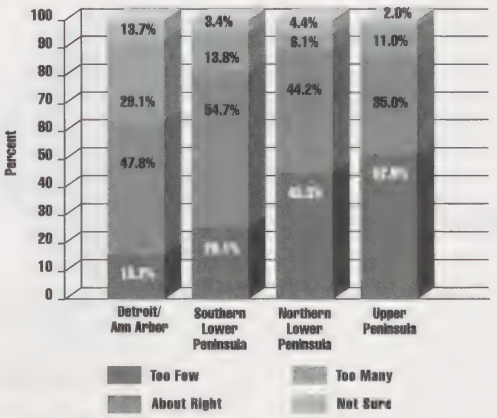
Physicians were asked to rate the impact of the medical practice environment on a series of areas. Two-thirds of respondents said that their professional and personal satisfaction had decreased and nearly half said their emotional health had decreased. Less than 11% said any of the five areas had improved as a result of the changes in medical practice.

When asked if they planned to retire before age 65, 43% strongly agreed and another 18% said that they somewhat agreed with that statement. When asked to rate areas that were influencing their decision to retire, fear of litigation and government regulation were the most commonly cited. A slightly higher percentage of rural physicians were considering early retirement than urban physicians.

Supply of Physicians

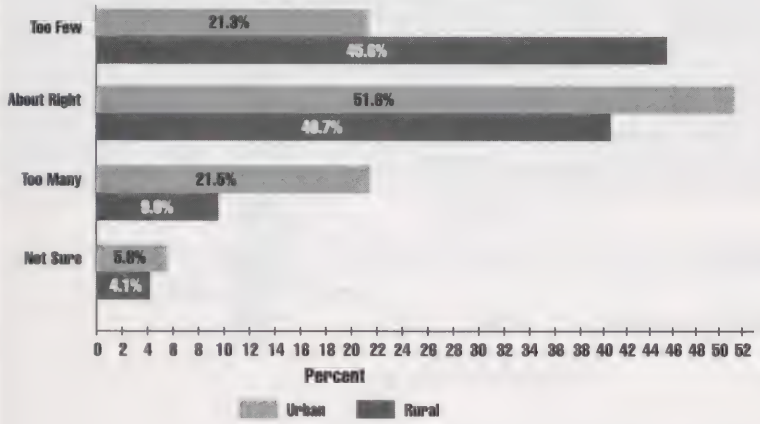


Supply of Physicians by Region

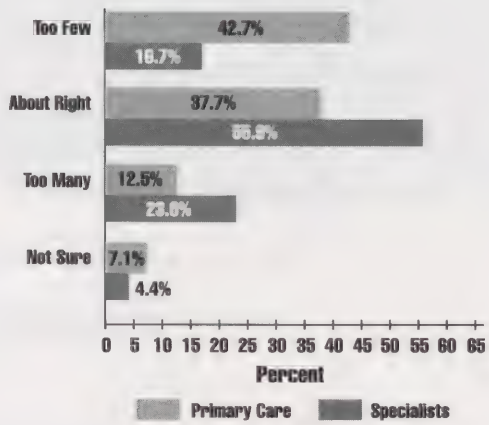


PRACTICE ENVIRONMENT *continued*

Supply of Physicians by Location



Supply of Physicians by Specialty Type



Physicians Leasing Company, Inc.

Your automotive and light duty truck source

A MSMS Member Benefit Program

The important first step on the way to your next car!



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Lease or purchase program

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Delivery - No longer do you have to take time out to take delivery of your new vehicle. PLC brings it right to you, either at the office or at home.

Shopping - With our fleet connections we do the shopping for you. PLC experts will find the lowest available price for that special car you want.

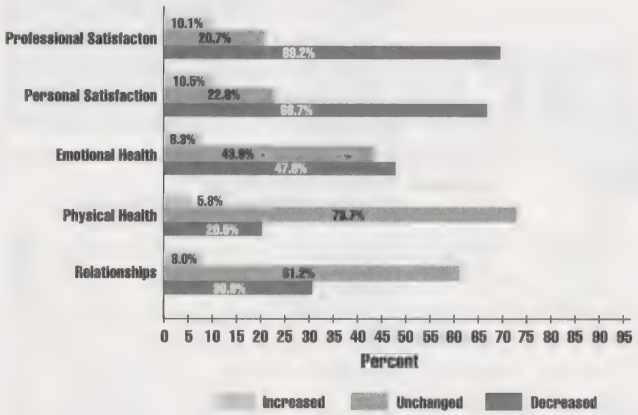
Financing - PLC can take care of it all, purchase, lease, First Time Buyer, and Intern Financing, at the lowest rates available.

Trade-Ins - Yes, PLC will even take in your old car. We will do it all by phone to save you the headaches.

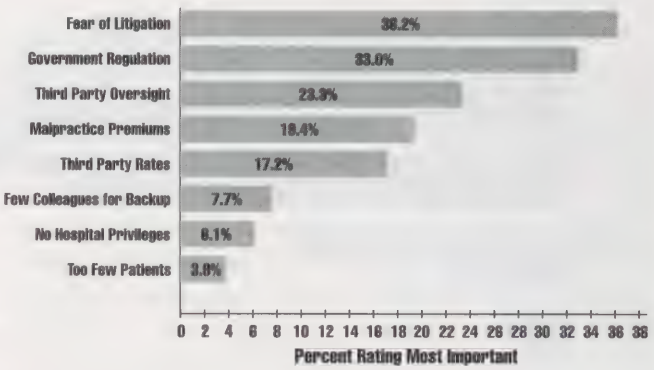
Used cars - Looking for a second car? A car for the kids? Give PLC a call; we always offer a fresh supply of good clean trade-ins.

Contact our staff today!

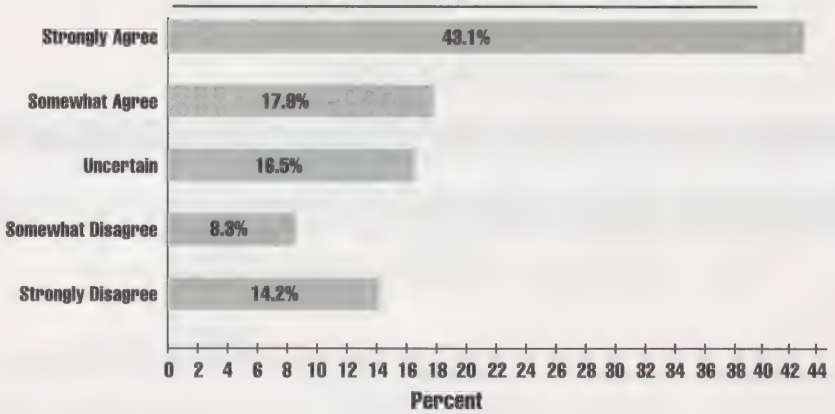
Changes Due to Practice Environment



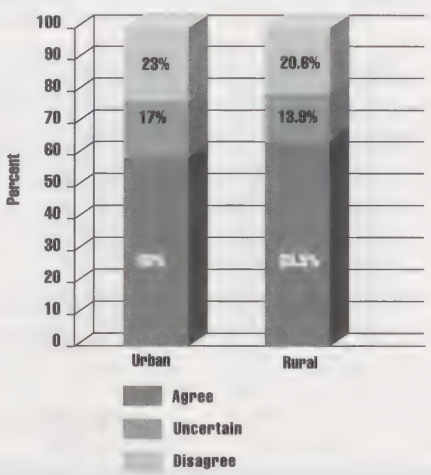
Factors in Considering Retirement



Considering Retirement Before Age 65



Considering Retirement Before Age 65 by Location





Is your practice *too* busy?

- ❑ **Is it hard to plan a vacation?**
- ❑ **Is it hard to keep up with both office and hospital?**
- ❑ **Is revenue static while demands on your time increase?**
- ❑ **Are your patients complaining about lengthy waits for appointments?**
- ❑ **Do you wish you could have the same 1st assistant for every surgery?**

If you answered *yes* to any of these problems, a Physician Assistant (PA) may be the answer.

Consider the advantages of employing a PA:

- Licensure and National Boards serve as assurances of competence
- Malpractice policy rates are low
- Patient and staff acceptance is very high
- Revenues rise 2 to 3 times the PA's costs
- Appointment waiting time decreases
- Another medical provider for your office and rounds without the problems of adding a new partner
- Services are billable for PA office and surgery services (some exceptions)

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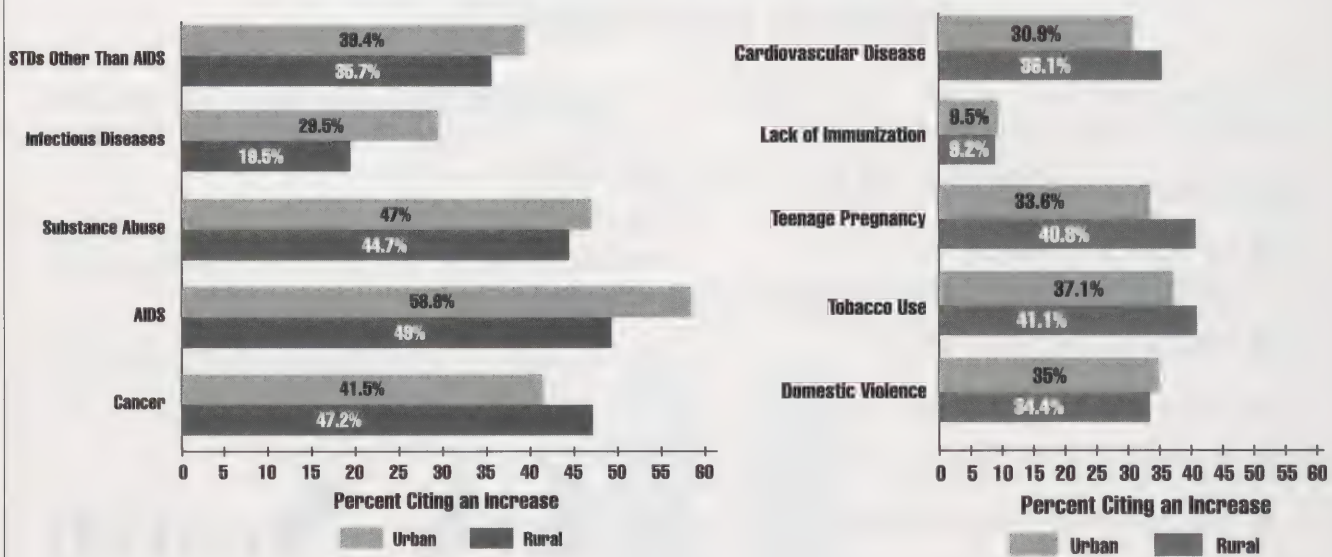
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COMMUNITY ENVIRONMENT

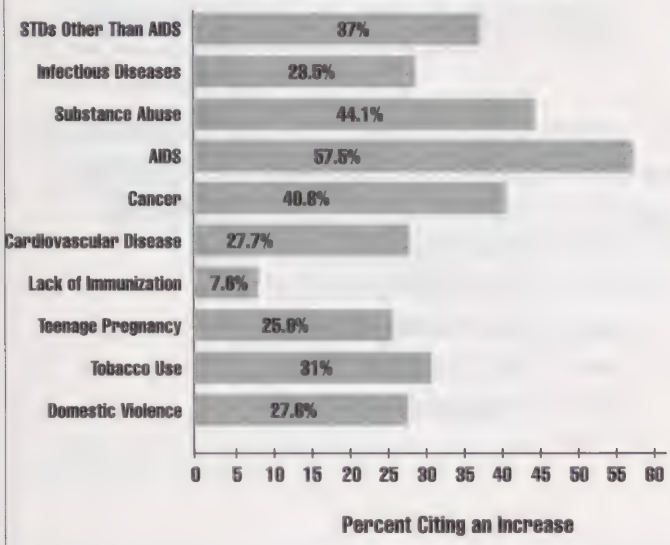
Physicians indicated which health problems had increased in their practice in the last five years. Urban physicians said that AIDS (59%) and substance abuse (47%) were the problems that increased the most, while rural physicians cited AIDS (49%) and cancer (47%). When asked how questions from patients had changed over the last five years, more physicians said questions on screening procedures and diet or nutrition had increased in both urban and rural areas.

Water quality, landfills and medical waste disposal are the most frequently cited community environmental problems. Air pollution and lead poisoning are more frequently cited by urban physicians than rural physicians. When asked how the same environmental problems affected their practice, over one-third said medical waste disposal had an impact.

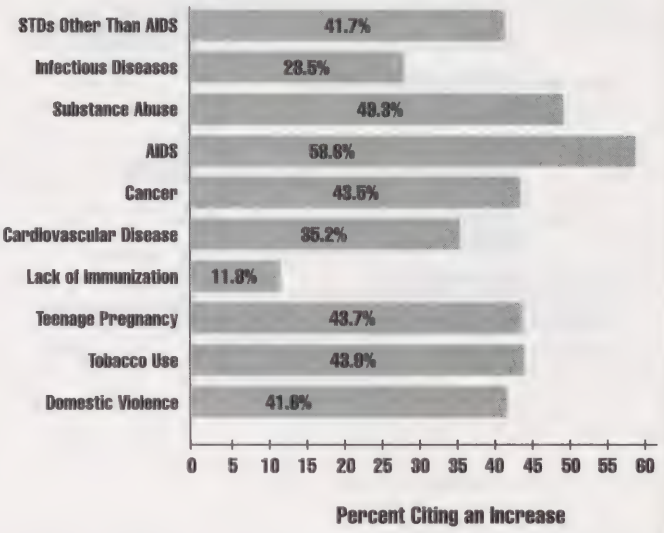
Health Problems Increasing in the Practice



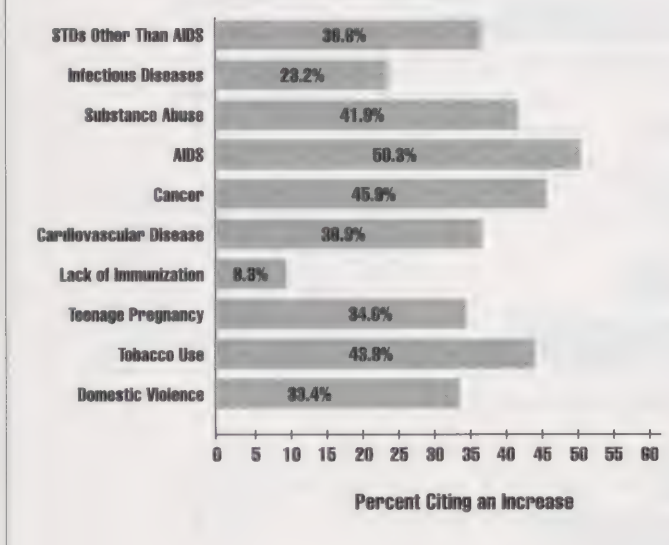
Increasing Health Problems in Detroit/Ann Arbor Metro area



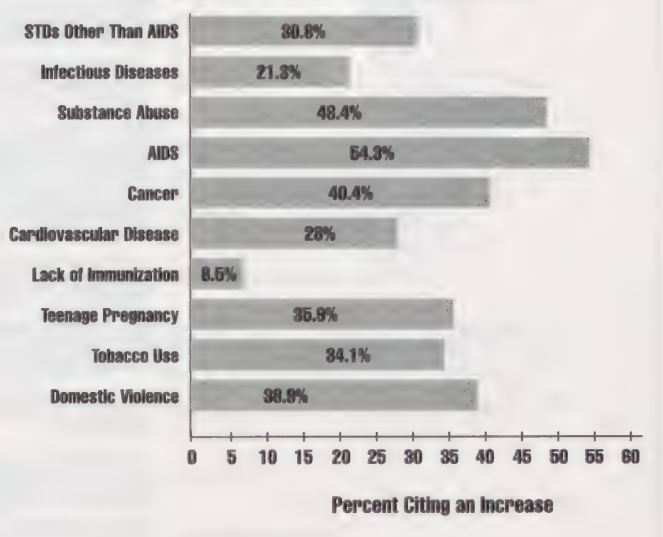
Increasing Health Problems in Southern Lower Peninsula



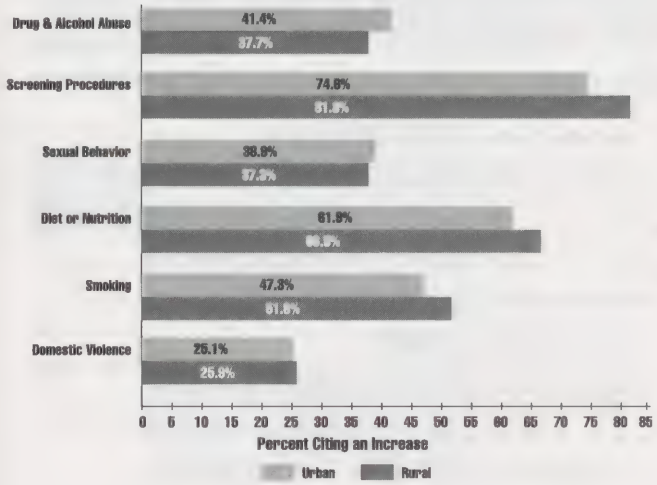
Increasing Health Problems in Upper Peninsula



Increasing Health Problems in Northern Lower Peninsula

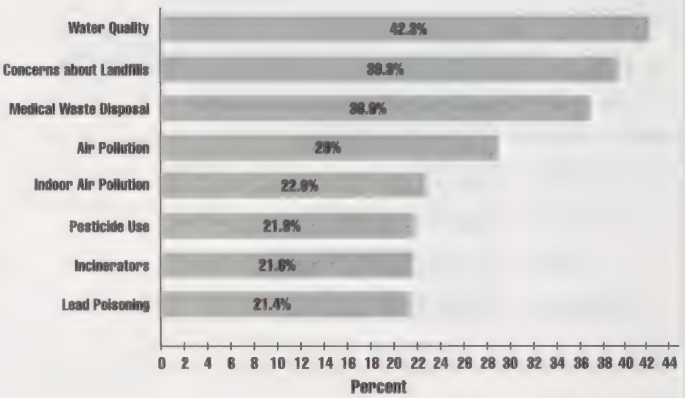


Increase in Patient Questions by Location*

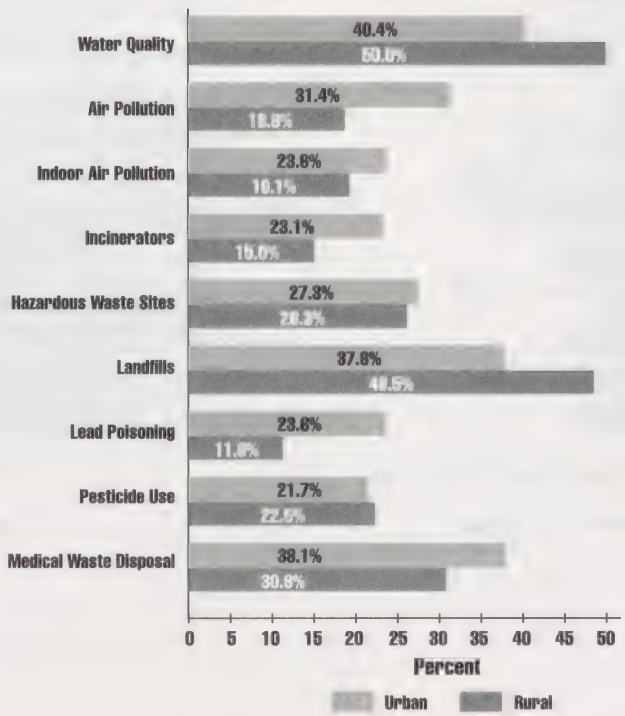


*In the past five years

Community Environmental Problems

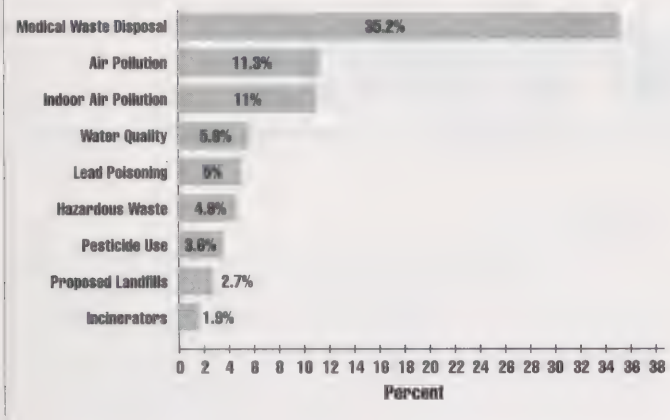


Community Environmental Problems by Location

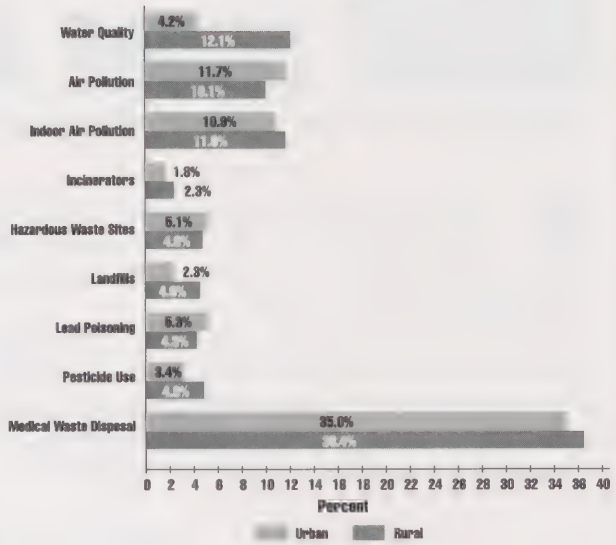


COMMUNITY ENVIRONMENT *continued*

Environmental Impact on Practice



Environmental Impact on Practice by Location



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HOURS AND SERVICES

The average respondent spent 47 weeks in practice in 1991 and worked an average of 61 hours per week. Eighty-two percent were on call in the previous month for an average of 185 hours per month.

One-half of physicians said they had limited the number of types of services they provide in the last five years. Fear of litigation, malpractice premiums and governmental regulation were the primary reasons for limiting services. Primary care and rural physicians were the most likely to have limited services.

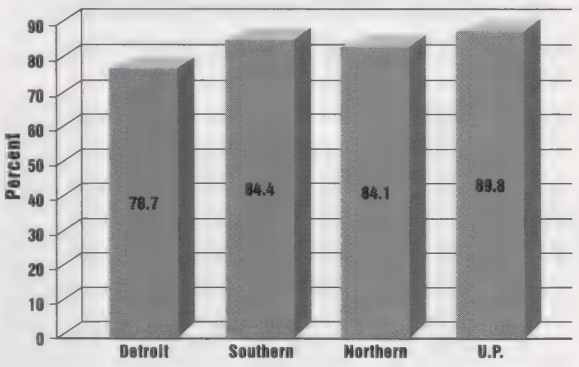
Two-thirds of physicians provided charity care, averaging 3.5 hours per week of free care and 3.9 hours per week of reduced fee care. Forty-percent of respondents said the amount of charity care they provide had increased in the last five years, and 46% said it had stayed the same as five years ago. A larger proportion of Upper Peninsula physicians provide charity care than in other regions.

Weeks and Hours in Practice

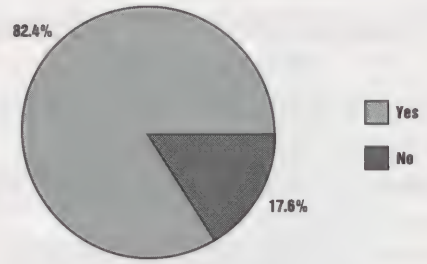
		1991 Weeks in Practice		Hours in All Professional Activities	
	Number of Responses	Mean	Standard Error	Mean	Standard Error
Anesthesiology	75	45.3	0.5	66.6	1.9
Dermatology	41	47.1	0.8	48.7	2.7
Diagnostic Radiology	41	44.4	0.5	60.9	2.3
Emergency Medicine	52	47.5	0.6	61.9	1.8
Family Practice	249	47.5	0.3	63.4	1.2
General Surgery	119	47.6	0.3	63.4	1.5
Internal Medicine	173	48.4	0.2	61.4	1.3
Obstetrics/ Gynecology	132	47.6	0.3	68.6	1.6
Ophthalmology	72	45.9	0.6	55.2	1.6
Orthopedic Surgery	70	46.4	0.5	66.2	2.1
Otolaryngology	35	48.0	0.4	61.5	3.8
Psychiatry	81	47.3	0.5	54.3	1.8
Pediatrics	89	47.8	0.3	61.0	2.1
Pathology	52	46.4	0.4	55.7	1.6
Radiology	66	44.3	0.6	56.1	1.5
Urology	45	47.1	0.4	59.3	2.4

HOURS AND SERVICES *continued*

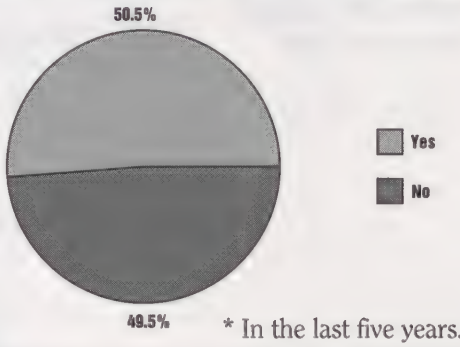
Physicians on Call by Region



On Call Last Month



Limited Number or Types of Services*

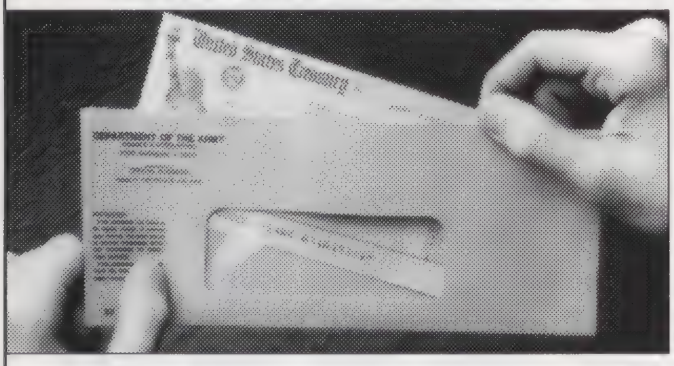


* In the last five years.

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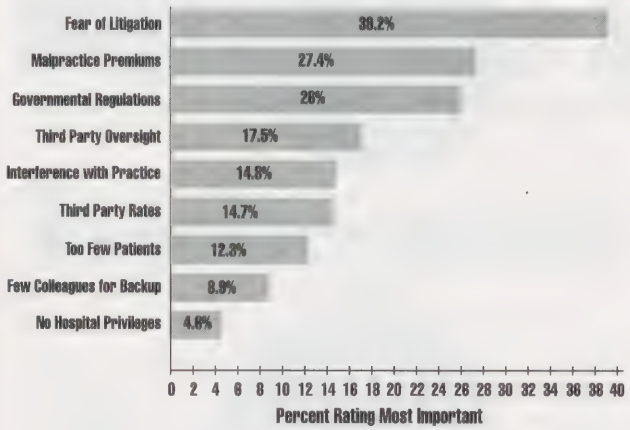
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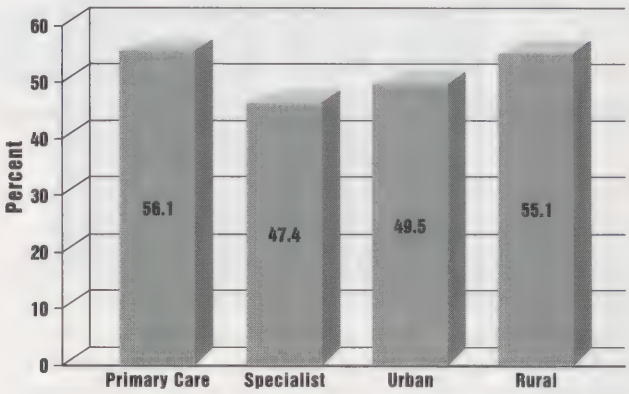
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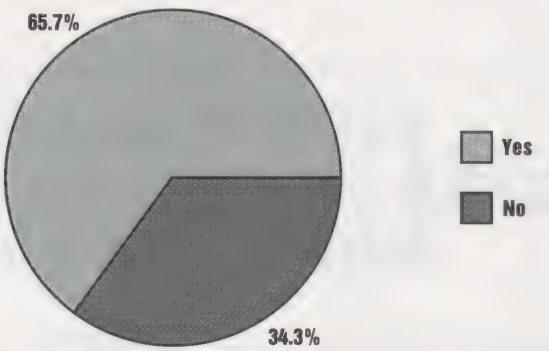
Reason for Limiting Services



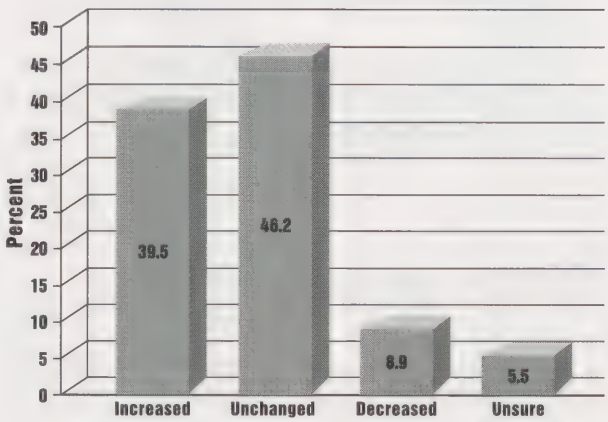
Physicians Limiting Services by Specialty and Location



Provided Charity Care

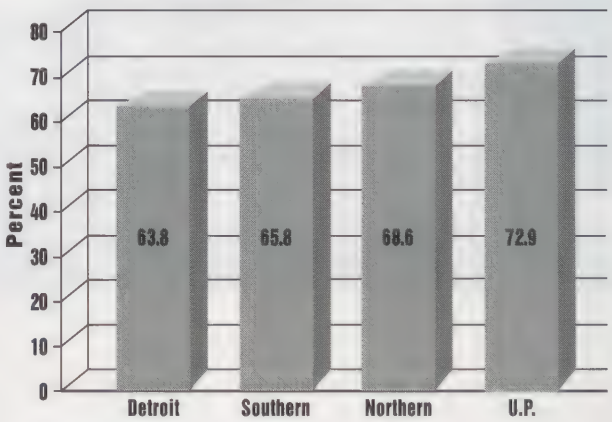


Change in Charity Care*



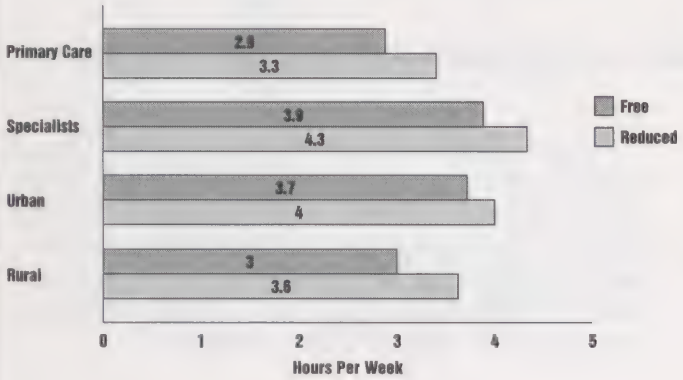
* In the last five years

Charity Care by Region

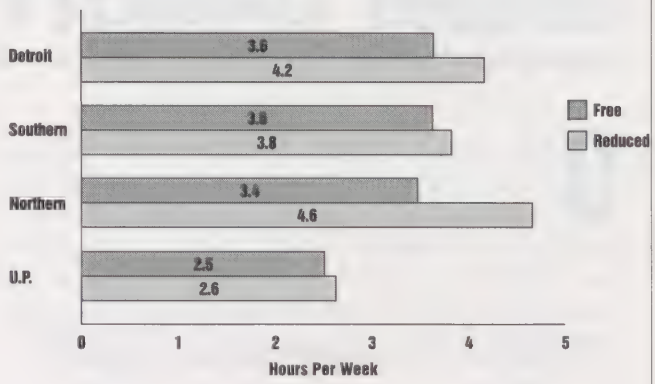


HOURS AND SERVICES *continued*

Hours of Free Care and Reduced Fee Care by Specialty Type and Location



Hours of Free Care and Reduced Fee Care by Region



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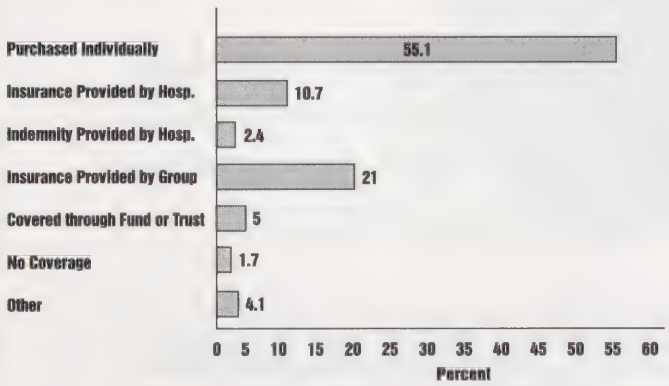
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Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

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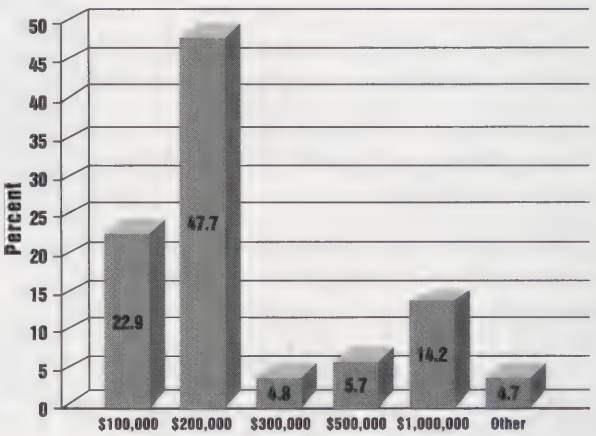
LIABILITY

Over one-half of physicians in the survey purchase professional liability insurance individually, 21% have it provided by the group practice and 11% have it provided by the hospital. Nearly one-half of respondents have a $200,000 per case limit and a $600,000 annual limit. Coverage of $100,000/$300,000 was more common in the Detroit/Ann Arbor metropolitan area and $1,000,000/$3,000,000 coverage was more common in the Upper Peninsula, perhaps because of affordability. Sixty percent of respondents had had a liability suit brought against them in their career, with Detroit/Ann Arbor physicians having the highest frequency and the highest average number of suits brought. Very few physicians had judgments or settlements that exceeded the amount of their coverage.

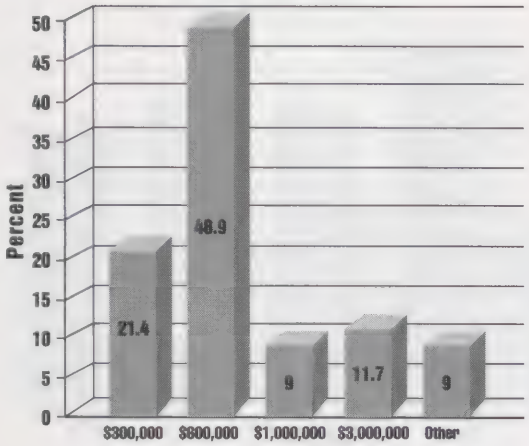
Source of Liablity Coverage



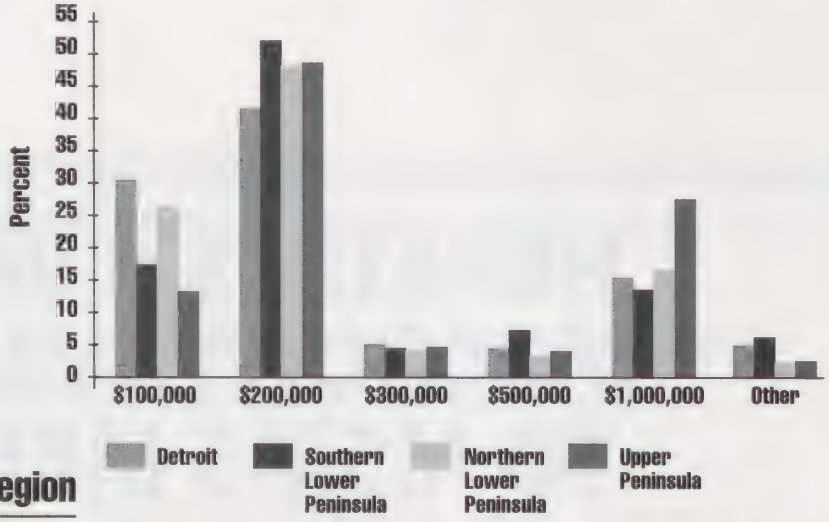
Liability Per Case Limits



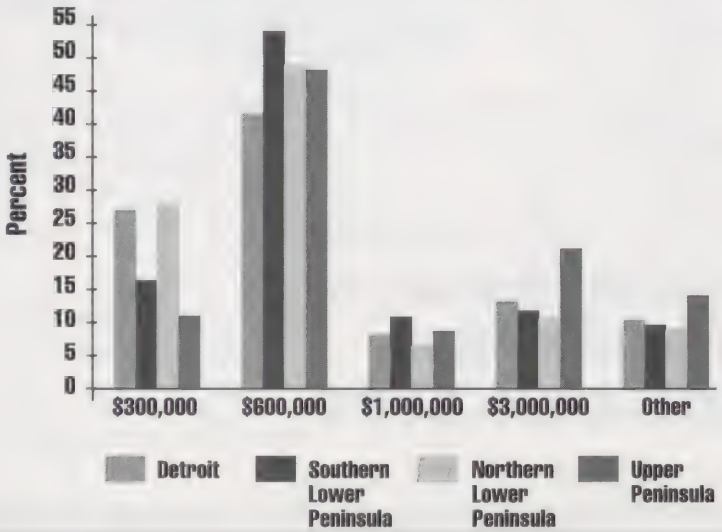
Liability Annual Limits



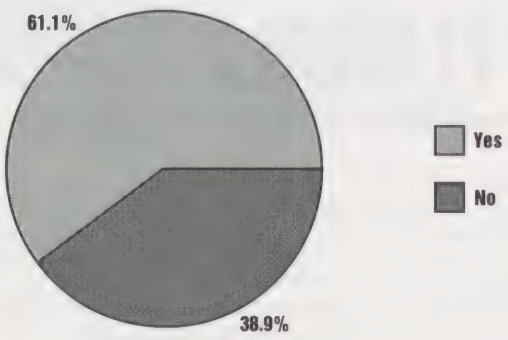
Liability Per Case Limits by Region



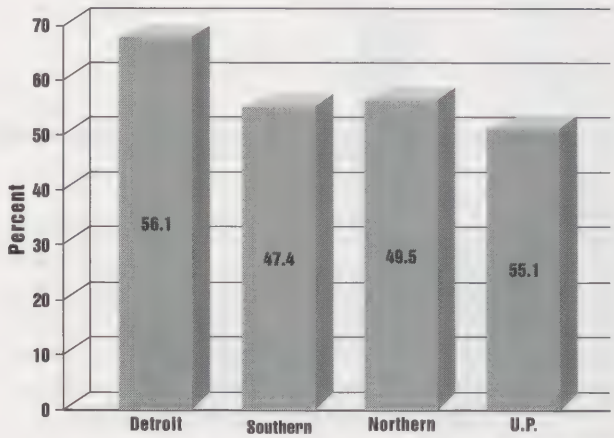
Liability Annual Limits by Region



Ever Had a Liability Suit Brought



Liability Suit by Region



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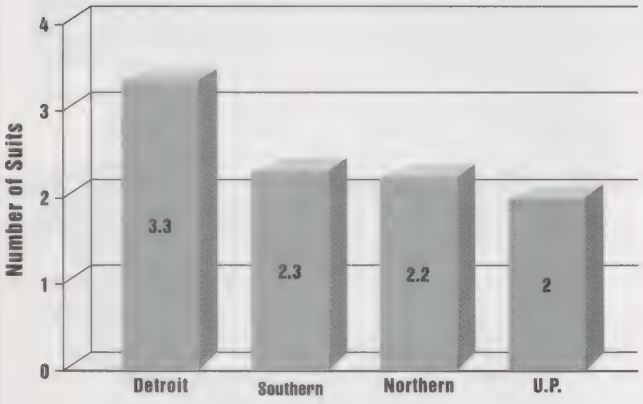
For detailed information call Sandy at

Bond Wholesale Pharmaceutical and Medical Supply

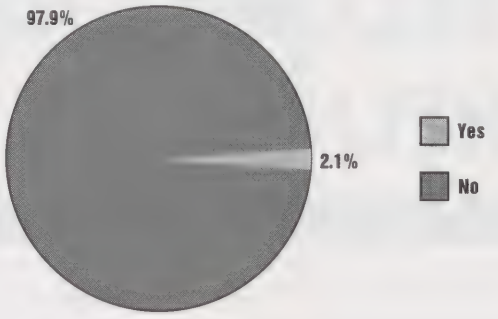
1-800-989-1199

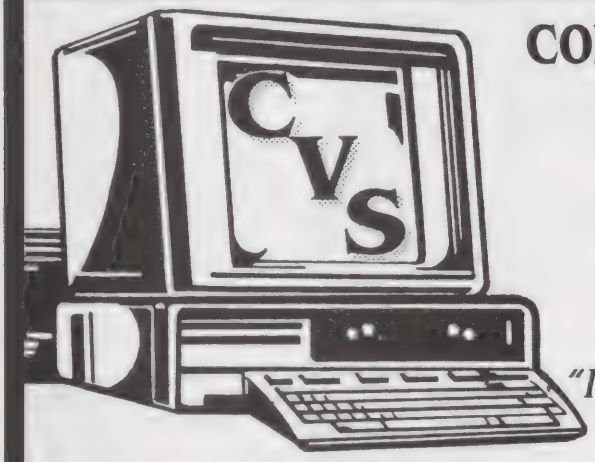
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Average Number of Suits Brought by Region



Judgements or Settlements Above Limit





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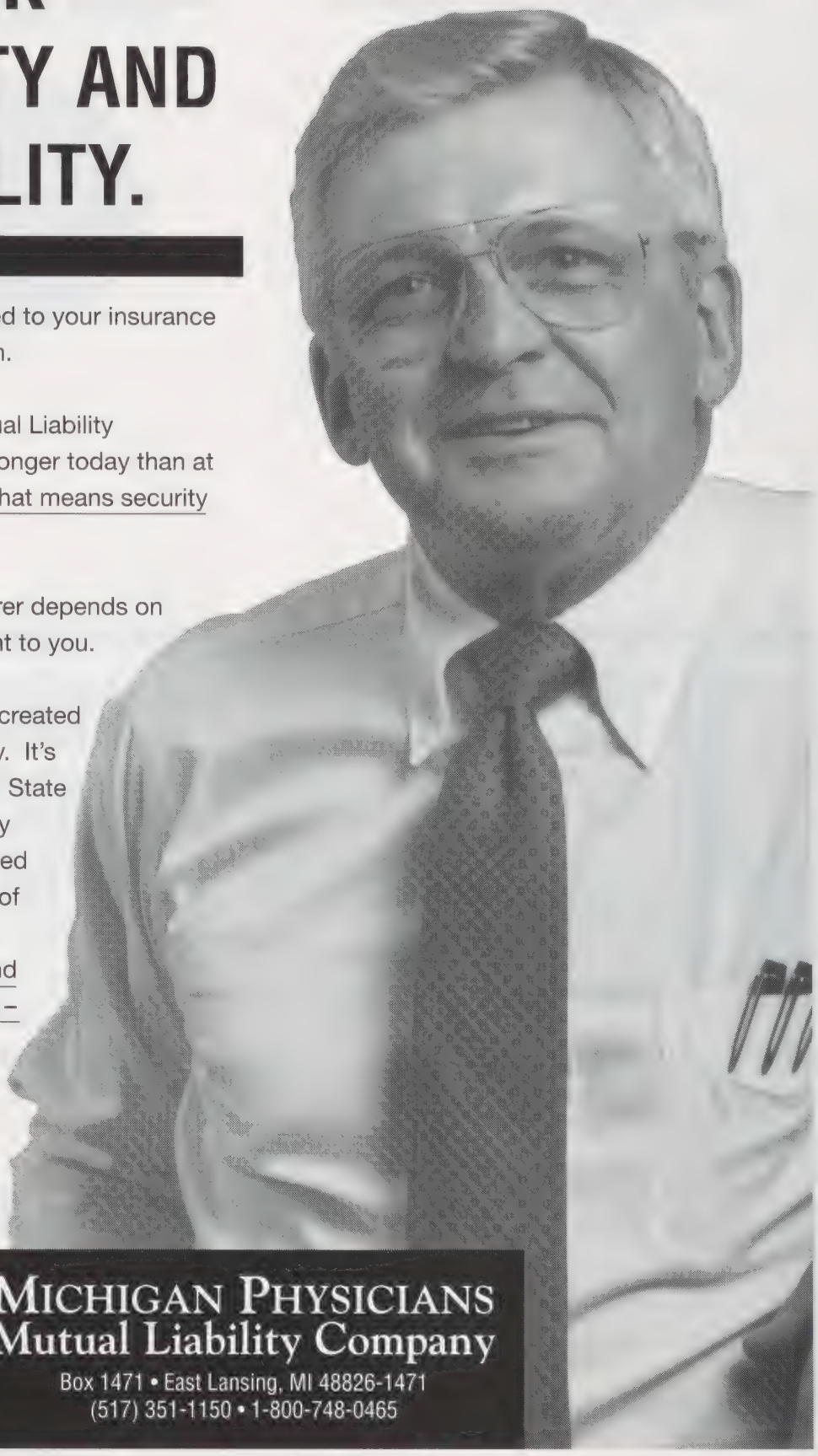
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THIRD PARTY PAYERS

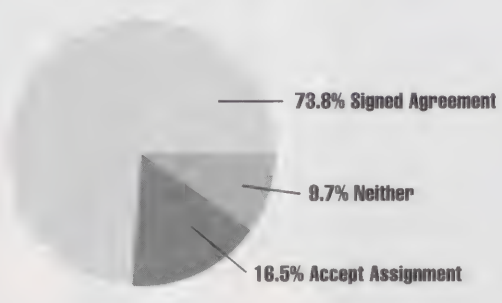
Nearly three-quarters of respondents are participating physicians in the Medicare program and another 16.5% accept assignment on a per case basis. The Detroit/Ann Arbor metropolitan area has the highest percentage of participating physicians, and the Northern Lower Peninsula has the highest proportion of physicians that accept assignment. Specialists are more likely to participate than primary care physicians, and urban physicians are just slightly more likely to participate than rural physicians. When asked about reimbursement under the Resource Based Relative Value Scale (RBRVS), 44% say that it has decreased and 12.6% say it has increased. Specialists and urban physicians are more likely to say reimbursement has decreased under RBRVS, and 80% of rural physicians say it has increased. Nearly all physicians that currently see Medicare patients say they will continue to do so, although it is not known how many will accept new Medicare patients in their practice.

Two-thirds of respondents signed the Blue Cross Blue Shield of Michigan (BCBSM) participation contract, and approximately one-fifth accept assignment on a per case basis. The largest proportion of participating physicians is in the Northern Lower Peninsula, followed closely by the Detroit/Ann Arbor metropolitan area. Primary care physicians were equally as likely as specialists to sign the participation contract but were slightly more likely to accept per case assignment.

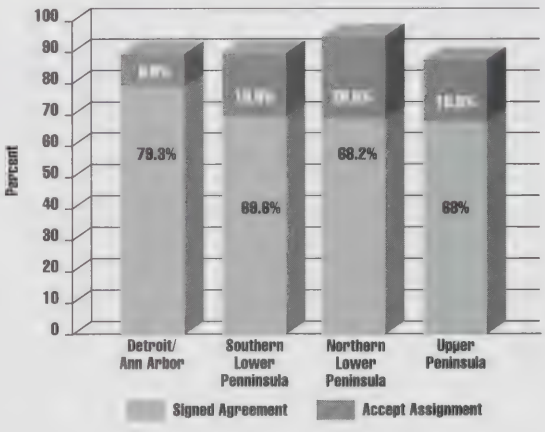
Nearly one-half of respondents accept Medicaid patients without limits, another third accept them but in limited numbers. When asked why they do not see Medicaid patients or limit the number that they accept into their practice, reimbursement and other payment issues were the primary reasons. Physicians in the Northern and Upper Peninsula regions are more likely to accept Medicaid patients without limitations.

Two-thirds of physicians had a contract in 1992 with health maintenance organizations (HMOs), independent practitioner associations (IPAs) and preferred provider organizations (PPOs). Nearly 40% say they have regretted affiliating with a managed care plan. Sixty percent say they have been prevented from providing a treatment or service that they felt was medically necessary because the insurer would not pay for it, and 55% have been denied payment retrospectively. Nearly two-thirds say that financial incentives and limitations in reimbursement plans have affected their ability to exercise medical judgment.

1992 Medicare Participation



Medicare Participation by Region



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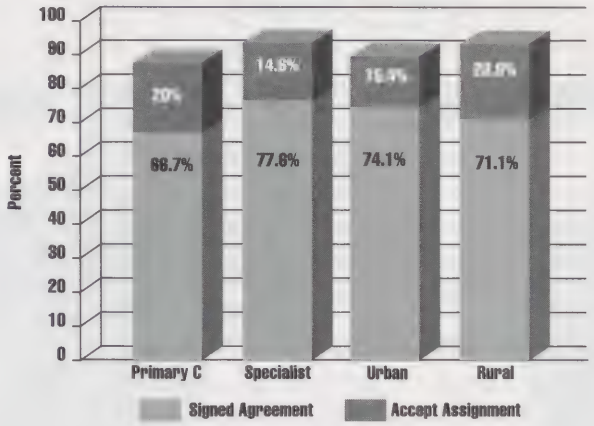
For more information, call us at 1-800-968-7518 or (313) 939-5900.

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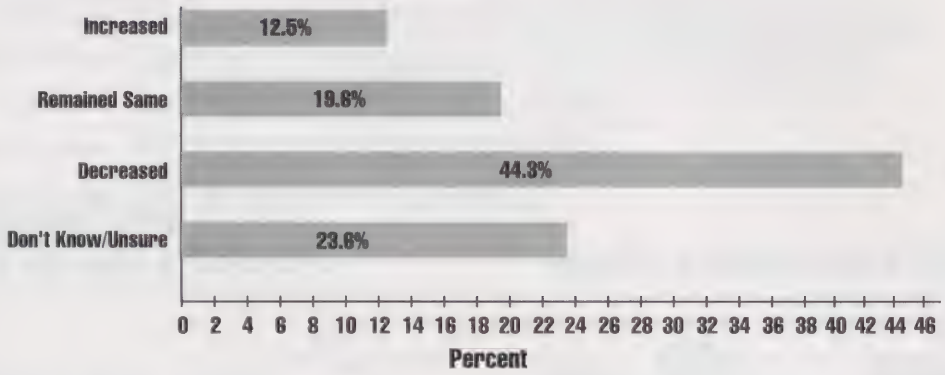
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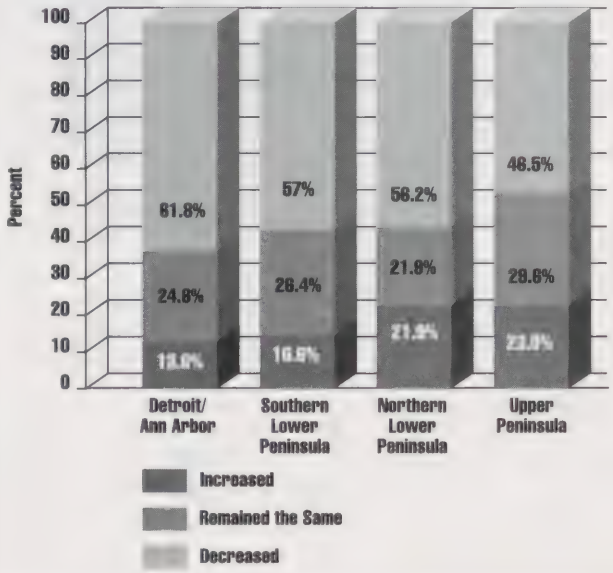
Medicare Participation by Specialty Type and Location



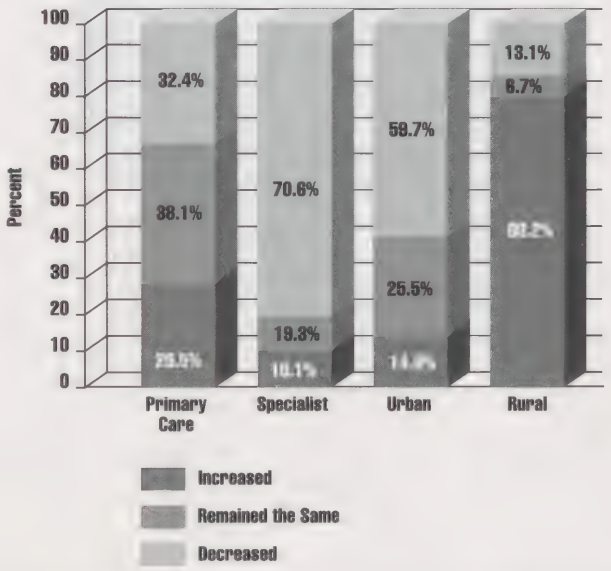
Reimbursement Under RBRVS



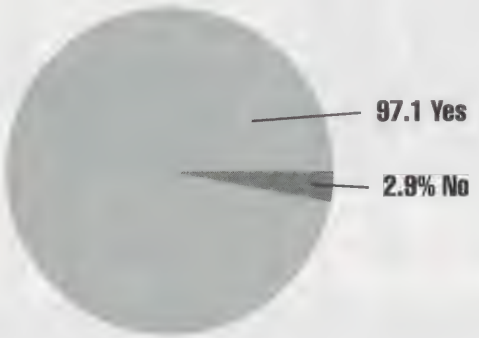
Reimbursement Under RBRVS by Region



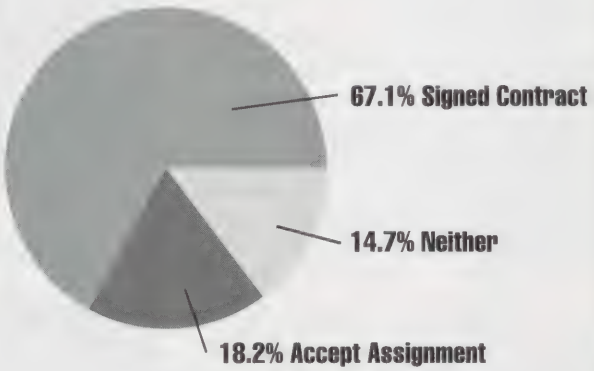
Reimbursement Under RBRVS by Specialty Type and Location



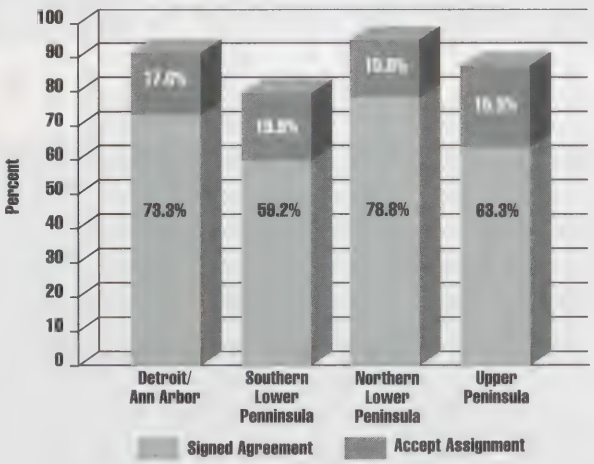
Continue Seeing Medicare Patients



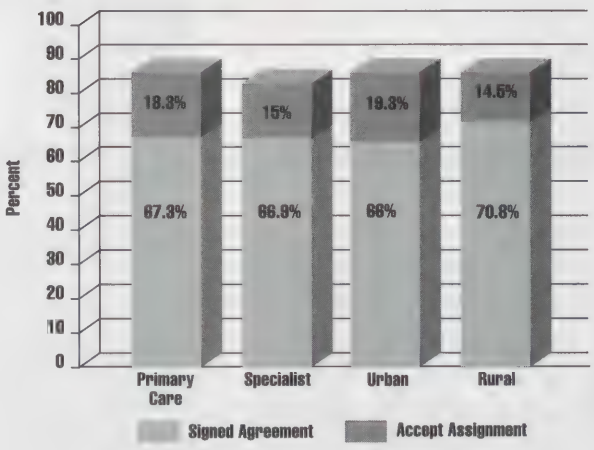
1992 BCBSM Participation



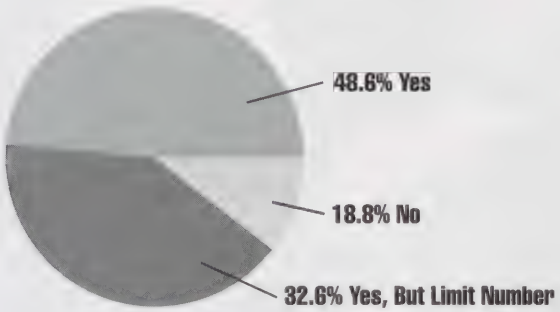
BCBSM Participation by Region



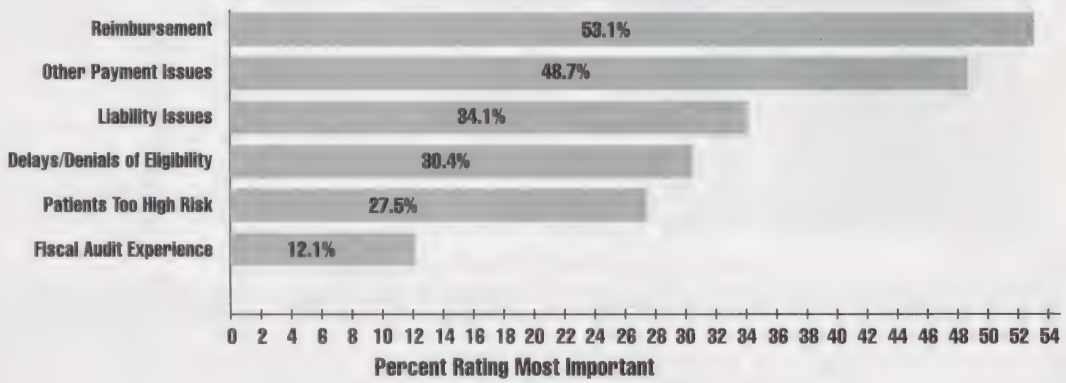
1992 BCBSM Participation by Specialty Type and Location



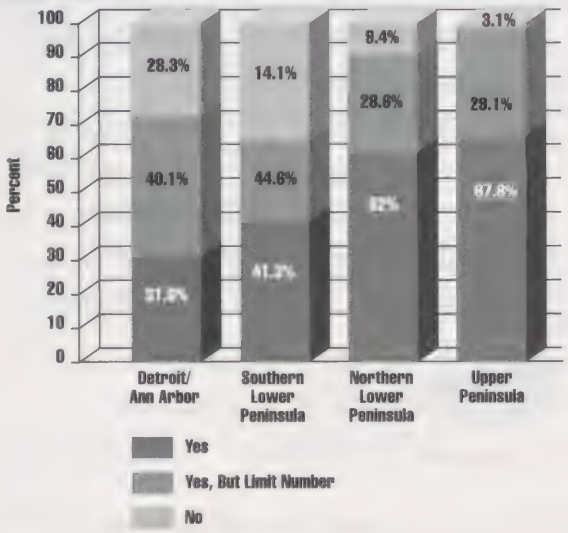
Accept Medicaid Patients



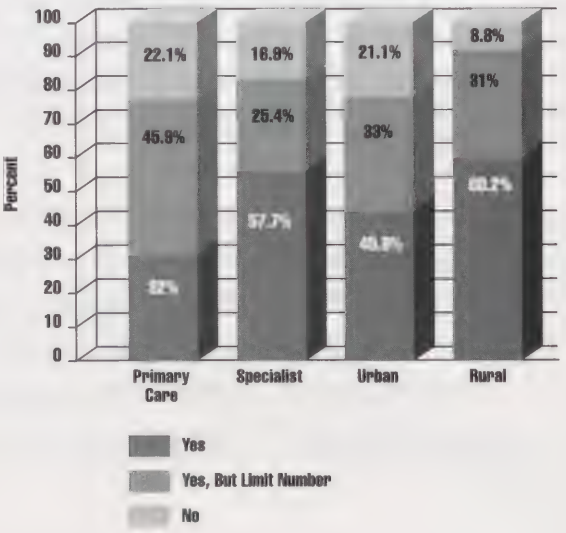
Reasons for Limiting/Not Seeing Medicaid Patients



Accept Medicaid Patients by Region



Accept Medicaid Patients by Specialty and Location





Growing older can't be helped. Feeling older can.

Growing old gracefully isn't always easy.

That's why having excellent medical care is important. Treating older adults means responding to their special needs for expert medical care and personal independence.

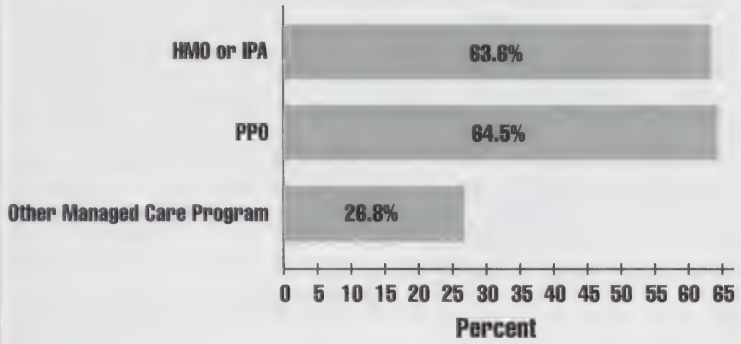
At Rehabilitation Institute of Michigan, we understand aging brings many changes, including chronic illness, sensory problems and orthopedic conditions causing physical and neurological limitations. We know that treating these problems can mean the difference between independent living and supervised care.

Our goal is to work with you to maintain your patients' independence as long as possible. We have a specialized geriatric unit devoted to caring for older adults.

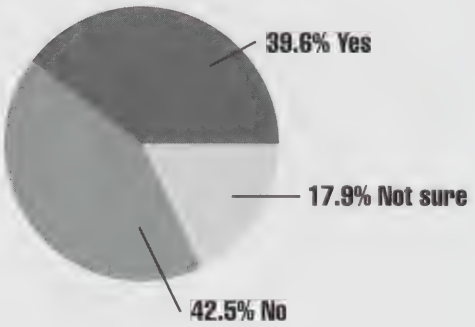
After more than 40 years of helping people rebuild their lives, we think we know a little about aging gracefully. For more information on our geriatric services or to make a referral, call us at **(313) 745-9716**.

DMC Wayne State University Rehabilitation Institute of Michigan

Proportion of Physicians with Contracts in 1992



Regret Affiliating with Managed Care



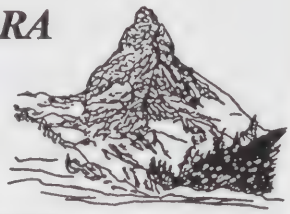
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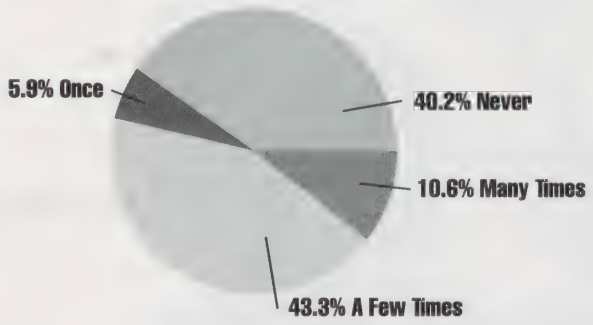
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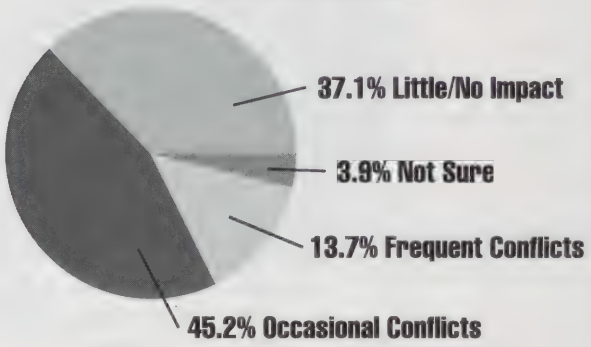
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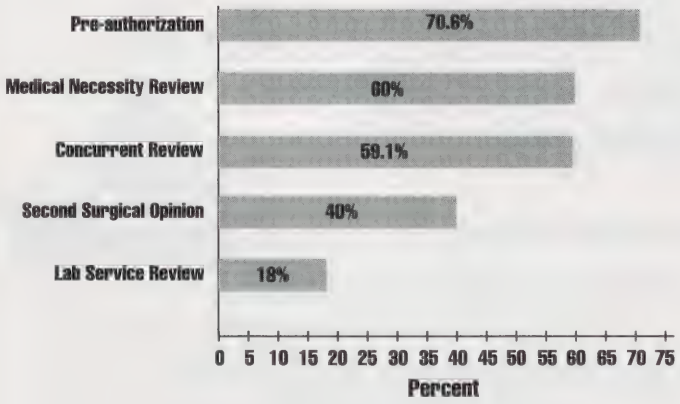
Prevented from Providing Noncovered Treatment



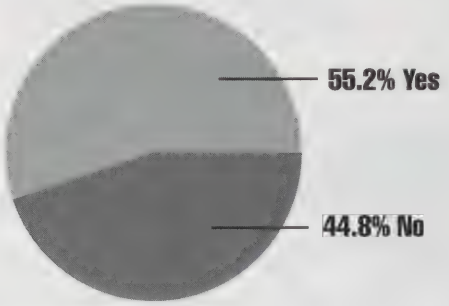
Impact of Reimbursement Plans on Medical Judgement



Utilization Review Activities



Been Denied Payment Retrospectively



Over two-thirds of physicians surveyed are subject to pre-authorization requirements and another 60 percent experience medical necessity review. More than one-half of respondents have had payment denied retrospectively for care that has been rendered.



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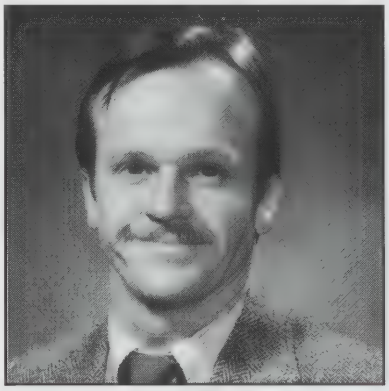
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presents the winners of the 1992 President's Achievement Award

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Freda D. Jackson
Annapolis, Michigan



John B. Stevens
University of Michigan



Jeffrey A. Walker
Michigan State University

MSMS MD data

FINANCE

The average gross revenue per physician is $343,600. The average for total professional expenses is $191,800. The average for net income is $161,000, with a median of $140,000. Because financial figures tend to be influenced by extremes, the median may be a better reflection of what the "average" physician experiences.

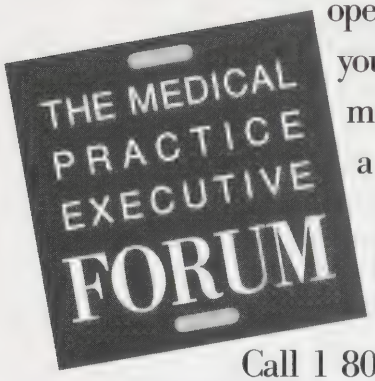
Gross Revenues per Physician (in Thousands of Dollars), 1991

	Number of Responses	Mean	Standard Error	25th Percentile	Median	75th Percentile
Region						
Detroit/Ann Arbor	508	378.3	35.2	146.0	255.0	400.0
Southern Lower Peninsula	524	320.5	9.9	195.5	260.0	400.0
Northern Lower Peninsula	116	311.8	30.2	160.3	240.0	343.9
Upper Peninsula	70	311.0	37.4	170.0	247.5	350.0
Location						
Urban	979	352.4	19.1	169.5	260.0	400.0
Rural	236	308.8	17.1	180.0	245.0	350.0
Specialty Type						
Primary Care	452	269.5	14.9	152.5	228.0	300.0
Specialist	761	389.8	23.4	190.0	300.0	450.0
Michigan	**1223**	**343.6**	**15.7**	**170.0**	**250.0**	**400.0**

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Medical Practice Executive Forum Registration Card

Name _____ Title _____

Practice Name _____

Address _____ Phone _____

City _____ State _____ Zip _____

City and date I will be attending: ☐ **Detroit, MI (5/12)** ☐ **Cincinnati, OH (5/19)** ☐ **Columbus, OH (5/26)** ☐ **Erie, PA (6/2)** ☐ **Cleveland, OH (6/9)**

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44114-9564
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Total Professional Expenses per Physician (in Thousands of Dollars), 1991

	Number of Responses	Mean	Standard Error	25th Percentile	Median	75th Percentile
Region						
Detroit/ Ann Arbor	450	247.5	62.9	460.0	123.5	210.0
Southern Lower Peninsula	490	157.7	6.5	75.0	125.0	200.0
Northern Lower Peninsula	106	132.4	9.2	59.0	108.0	194.0
Upper Peninsula	64	158.0	22.8	63.3	130.0	198.0
Location						
Urban	888	201.9	32.0	58.5	125.0	200.0
Rural	218	152.5	12.2	75.0	115.5	193.3
Specialty Type						
Primary Care	405	225.7	69.3	80.0	121.0	180.0
Specialist	698	173.6	7.5	50.0	125.0	216.0
Michigan	**1113**	**191.8**	**25.7**	**60.0**	**124.9**	**200.0**

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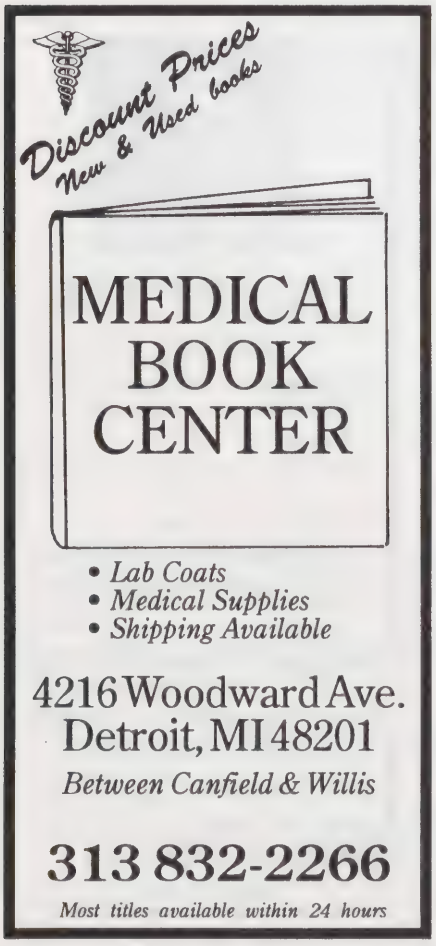
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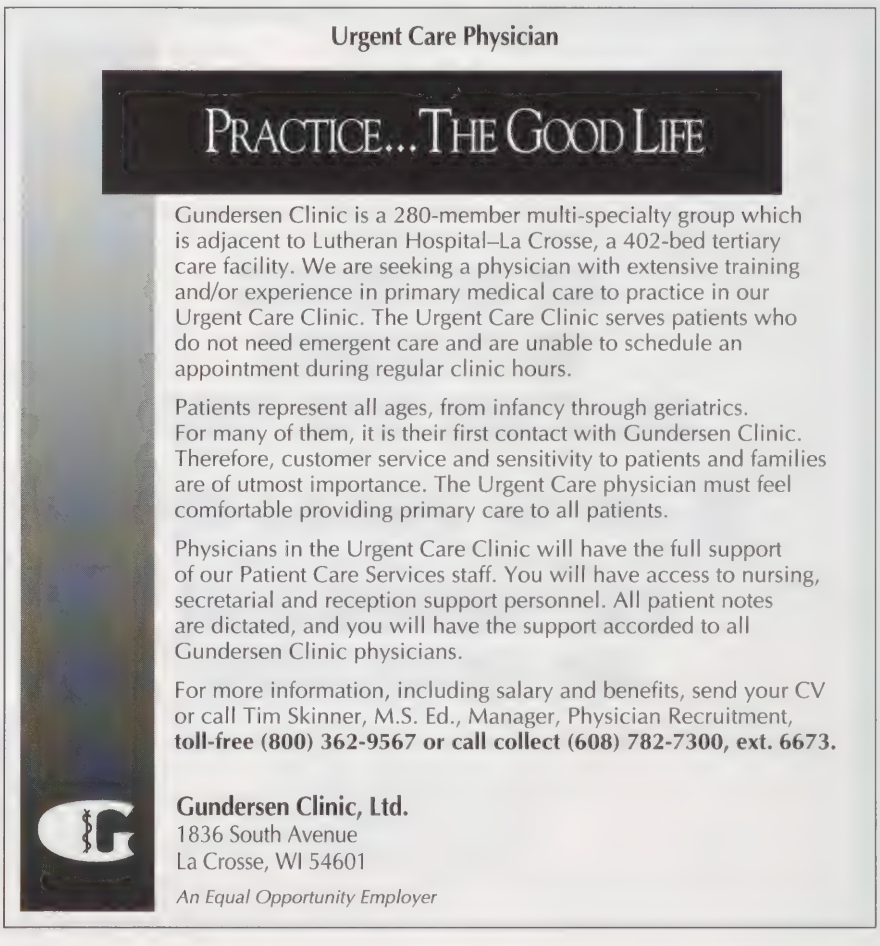
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(800) 292-1960
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MEMBERS NYSE/SIPC

Net Income After Expenses Before Taxes Per Physician (in Thousands of Dollars), 1991

	Number of Responses	Mean	Standard Error	25th Percentile	Median	75th Percentile
Region						
Detroit/ Ann Arbor	586	165.6	3.9	100.0	150.0	200.0
Southern Lower Peninsula	650	164.8	3.9	100.0	140.0	200.0
Northern Lower Peninsula	137	134.9	6.7	85.5	120.0	172.5
Upper Peninsula	83	137.7	9.3	80.0	117.2	174.0
Location						
Urban	1170	166.3	2.8	100.0	145.0	200.0
Rural	283	140.0	5.0	86.0	120.0	177.0
Specialty Type						
Primary Care	546	113.7	2.6	80.0	103.0	132.5
Specialist	905	190.1	33.3	120.0	175.0	242.7
Michigan	**1463**	**161.0**	**2.5**	**100.0**	**140.0**	**200.0**





TECHNICAL NOTES

Some figures may not total exactly to 100% due to rounding errors. Unless otherwise indicated, percentages are the proportion of survey respondents who indicated a given answer.

Some questions in the survey are not presented here. They do not have special significance by themselves but will serve as benchmarks for changes over time, particularly as health reform is implemented, and will be reported as trend lines in the future.

Where information is presented by specialty, only those with more than 30 respondents are reported. Following are the response fates for those specialties.

Specialty	Response Rate (%)
Anesthesiology	17.5
Dermatology	25.3
Diagnostic Radiology	19.4
Emergency Medicine	29.1
Family Practice	30.6
General Practice	32.5
General Surgery	20.6
Internal Medicine	12.5
Obstetrics & Gynecology	19.2
Ophthalmology	21.4
Orthopedic Surgery	21.8
Otorhinolaryngology	26.6
Psychiatry	24.3
Pediatrics	18.2
Pathology	26.1
Radiology	21.5
Urological Surgery	21.8

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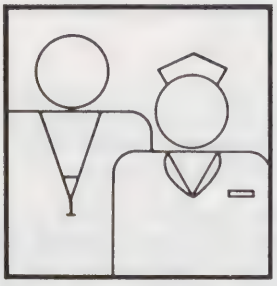
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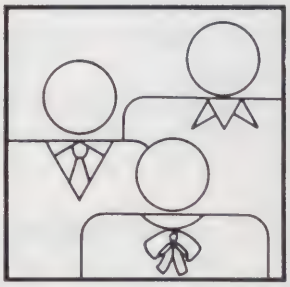
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

May

11, 12, 13, How To Comply with CLIA Regulations. Location: May 11, Holiday Inn Crown Plaza, Grand Rapids, Michigan. May 12, Grand Traverse Resort, Traverse City, Michigan. May 13, Holiday Inn, Marquette, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Tom Wolff, MSMS Regulatory Ombudsman, (517) 336-5740. **Approved for:** 3.5 hours Category I Credit.

11, 18, The Self Punitive Patient. Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

12, Advances in Benign Prostatic Hyperplasia and Cancer an International Symposium. Location: The Ritz Carlton, Dearborn, Michigan. **Sponsor:** Wayne State University and Harper Hospital. **Contact:** Wayne State University, Department of Urology, 4160 John R, Suite 1017, Detroit, MI 48201, (313) 745-7381. **Approved for:** 4 hours Category I Credit.

13, Flexible Sigmoidoscopy/Hemorrhoids. Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI 48640, (800) 462-2492. **Approved for:** 7.5 hours of Category I Credit.

13-14, Vestibular Rehabilitation. Location: Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

14-15, EGD (Gastroscopy). Location: Bay Valley Resort and Hotel, Bay City, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Judith Wright, Registration Coordinator, 4909 Hedgewood Dr., Midland, MI, 48640, (800) 462-2492. **Approved for:** 12 hours Category I Credit.

15, Update on Risk and Prevention of Occupationally Acquired Infections in the Health Care Worker. Location: Ritz Carlton Hotel, Dearborn, Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Office of Contiuing Medical Education, CFP-1, (313) 876-3073. **Approved for:** 3.5 hours Category I Credit.

17-22, All Michigan OB/GYN Review Course. Location: Radisson On The Lake, Ypsilanti, Michigan. **Sponsor:** Wayne State University School of Medicine, Wayne State University, University of Michigan and Michigan State University. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 37 hours Category I Credit.

21-22, Current Concepts in Pediatric Opthalmology and Strabismus. Location: W.K. Kellogg Eye Center, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 12.5 hours Category I Credit.

25, Treating Family Members in the Same Practice: Special Problems and Considerations. Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** Joseph Gluski, MD, 3000 Towne Center, Suite 1275, Southfield, Mi 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

26, Rheumatology-Pathogenesis and Treatment of Rheumatoid Arthritis. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of michigan Medical School. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 7 hours Category I Credit.

26, Effective Compassion for the Incurably Ill: Alternative to Assisted Suicide. Location: Amway Grand Plaza, Grand Rapids, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 6 hours Category I Credit.

June

1, Treating Family Members in the Same Practice: Special Problems and Considerations. Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

1, 2, Diagnosis and Management of Breast Cancer. Location: June 1, Novi Hilton, Novi, Michigan. June 2, WMU Regional Center, Grand Rapids, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

3-4, Current Topics in Blood Banking 20th Annual Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medial School, P.O.

Continued on following page

CATEGORY I COURSES

Continued from page 51

Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

4-5, Phonosurgery - Indications and Techniques. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

7-10, 6th Annual Summer Conference on Aging. Location: Novi Hilton, Novi, Michigan. **Sponsor:** Wayne State University School of Medicine, Institute of Gerontology. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180.

9-11, 11th Annual Laboratory information System Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 17 hours Category I Credit.

16, Eleventh Annual Research Conference. Location: Radisson Plaza hotel at the Kalamazoo Center, Kalamazoo, Michigan. **Sponsor:** Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, MSU/KCMS, Office of CME, 1535 Gull Road, Suite 230, Kala azoo, MI 49001, (616) 383-7363. **Approved for:** 8 hours Category I Credit.

21-25, 29th Annual, Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Marie McNight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400.

23, Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 6 hours Category I Credit.

July

11-13, 7th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort Village, Grand Traverse Resort, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 15 hours Category I Credit.

22-25, Ninteenth Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Michigan State Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, I 48106-1157, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

22-24, Advances in Office Psychiatry II: Mood and Anxiety Disorders. Location: Grand Traverse LResort, Grand Traverse Resort Village, Michigan. **Sponsor:** University of Michigan Medical School and the Michigan Psychiatric Society. **Contact:** Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 12 hours Category I Credit.

29-30, 73rd Annual Collier Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, Michigan. **Sponsor:** Munson Medical Center and Medical Staff. **Contact:** Elaine Gaines, Medical Education, Munson Medical Center, 1105 Sixth St., Traverse City, MI 49684-2386, (616) 935-6546.

August

8-11, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Marie McKnight, Towsley Center for Contiuing Medical Education, Department of Postgraduate Medicine and health Care Professions, University of Michigan Medical School, P.O. LBox 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. **Contact:** Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 60 hours Category I Credit.

September

9-10, Critical Clinical Issues in the Care of the Elderly: Oral Health, Dysphagia, Aspiration and Pneumonia. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan and Cleveland Regional Medical Education Center, Department of Veteran Affairs. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 7 hours Category I Credit.

15, Diagnosis and Management of Myocardial Infarction. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

MICHIGAN STATE MEDICAL SOCIETY

& Seminars Conferences

for June & July 1993

JUNE

Carcinoma of the Breast: A National Liability Epidemic
June 1 Novi Hilton, Novi
June 2 WMU Regional Center, Grand Rapids
$157 MSMS members, $185 non-members

Improving Your Practice Productivity and Performance in the 1990's
June 15 Troy Marriott, Troy
June 16 Treasure Island, Saginaw
June 17 Fetzer Center, Kalamazoo
$175 per participant for first member
$155 for additional member from the same practice

Supervisory Skills Series - Part III (How to Build an Effective Office Team)
June 8 Best Western Domino Farms, Ann Arbor
June 9 Treasure Island, Saginaw
June 11 Treetops Sylvan Resort, Gaylord
$175 per session for MSMS/other members
$225 per session for non-members

Medical Biller Training Series (Blue Cross/Blue Shield)
June 14-15 Grand Traverse Resort, Traverse City
$300 per two-day session for MSMS/other members
$400 per two-day session for non-members

Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide
June 23 Radisson-on-the-Lake, Ypsilanti
$55 registration fee (Lunch included)

MSMS/AMA Young Physician Series

*** Joining a Partnership or Group Practice**
June 24 Radisson on the Lake, Ypsilanti
$160 MSMS/AMA members, $50 for their spouse
$200 non-members, $75 for their spouse

*** Starting to Practice Smart**
June 25-26 Radisson on the Lake, Ypsilanti
$335 MSMS/AMA members, $110 for their spouse
$435 non-members, $140 for their spouse

JULY

Professional Well-Being: The First Step in Providing Care to Others
July 9-12 Boyne Highlands, Harbor Springs
A weekend event for physicians, spouses, family and guests. Call the MSMS Office of Physician Education at (517) 336-5784 for more information

Medical Biller Training Series (Medicare)
July 21-22 Grand Traverse Resort, Traverse City
$300 per two-day session for MSMS/other members
$400 per two-day session for non-members

Orientation to the Medical Office
July 22-23 MSMS Headquarters, East Lansing
$95 per person MSMS/MMGMA/MSMA members or their office staff, $125 per person for non-members

If you or other staff in your office would like a detailed brochure on these and upcoming MSMS programs, please call the Office of Physician Education at (517) 336-5784.

Seminar and Conferences Early Registration Card

Please type or print clearly.

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Seminar Title: **Location** **Date** **Fee**

Name of Attendee (to register more than one person - copy form) Telephone#

Practice Name Specialty FAX #

Address

City State Zip

☐ MD ☐ DO ☐ Other _____
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Telephone Registration (517) 336-5784
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Carcinoma of the Breast: A National Liability Epidemic

June 1, 1993
Hilton Hotel
Novi

June 2, 1993
WMU Regional Center
Grand Rapids

Diagnosis and Management of Myocardial Infarction

September 15, 1993
Grand Traverse Resort
Traverse City

September 22, 1993
Hilton Hotel
Novi

September 23, 1993
WMU Regional Center
Grand Rapids

Colon and Prostate Cancer: Avoiding Two Common Malpractice Traps

November 3, 1993
WMU Regional Center
Grand Rapids

November 4, 1993
Hilton Hotel
Novi

All programs are from 8:30 am to 4:45 pm

MICHIGAN STATE MEDICAL SOCIETY

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RISK MANAGEMENT CLINICAL CONFERENCES FOR 1993

These clinical conferences address clinical situations that frequently contribute to medical liability lawsuits.

The costs for each of the conference is $157 for MSMS members and $185 for non-members.

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of 5 credit hours in Category I toward requirements for Michigan relicensure and the Physician Recognition Award of the AMA, provided it is completed as designed. Physicians insured with Michigan Physicians Mutual Liability Company (MPMLC) may receive merit rating credits applicable toward a 4 percent (4%) premium reduction for attendance at any one of these programs. For more information, contact MPMLC at 1-800-968-2421.

For more information about these and other MSMS programs, please contact the Office of Physician Education at (517) 336-5784.

MSMS/MPMLC
CLINICAL CONFERENCES
PAYMENT

☐ $157 registration fee is enclosed (Member)
☐ $185 registration fee is enclosed (Non-Member)

☐ Check *(Payable to MSMS)*

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MAIL WITH PAYMENT TO:
Michigan State Medical Society
120 W. Saginaw, P.O. Box 950
East Lansing, MI 48826-0950

PLEASE TYPE OR PRINT CLEARLY.

Name of Attendee (to register more than one person - copy form)

Seminar Date and Name

Practice Name

Specialty County

Address

Phone # Fax #

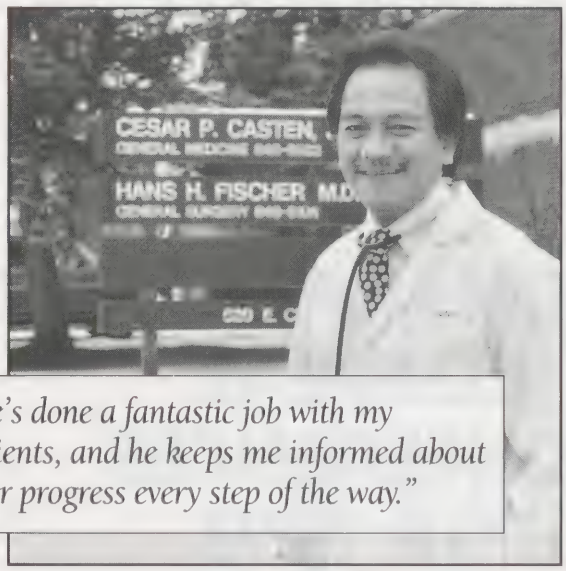
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HEALTHY RELATIONSHIPS



"He's done a fantastic job with my patients, and he keeps me informed about their progress every step of the way."

Dr. Cesar Casten
Family Practice, Standish

"The St. Luke's Specialist Referral Network introduced me to Dr. deBari. I work closely with a local foster home in our area that houses many individuals with paraplegia and other disabilities, and I frequently send these patients to Dr. deBari for the more specialized orthopedic care they need. It's a great relationship. I benefit. Dr. deBari benefits. And, of course, our patients benefit most of all."



Dr. Anthony deBari, Orthopedic Surgery
St. Luke's Specialist Referral Network

"I've only been practicing in this area for three years, and St. Luke's Specialist Referral Network has been very helpful in marketing my practice. I've had many doctors refer patients to me and consult with me about a patient. I'm more than happy to do that. After all, that's what the Specialist Referral Network is all about. Physicians helping physicians."

SPECIALIST REFERRAL NETWORK

It's a simple idea. Rural physicians call St. Luke's Specialist Referral Network when they need the advice or services of a specialist. The Network contacts the appropriate specialist, arranges a phone consultation or makes a referral appointment, then calls the rural physician with the information. No hassles. No waiting. A simple idea. And it's working.

When a healthy relationship with one of our specialists can help you and your patient, call the Specialist Referral Network at 1-800-541-3939.

St. Luke's Specialist Referral Network. Building healthy relationships among rural physicians, area specialists and their patients.

StLukes

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MEETINGS

MSMS Meetings

May

2, MSMS Board Meeting, Michigan State Medical Society, East Lansing, MI. Contact: William Madigan, MSMS Executive Director, (517) 336-5734.

3, 4, MSMS Coding Clinics for Specialties, May 3, WMU Regional Center, Grand Rapids, MI. May 4, Hotel Baronette, Novi, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

10,13, MSMS Opportunities 1993: An Array of Medical Practice Opportunities for Michigan Physicians. May 10, WMU Regional Center, Grand Rapids, MI. May 13, Best Western Domino Farms, Ann Arbor, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

11, MSMS/MPMLC Risk Management: Closed Claim Reviews (Pathology), WMU Regional Center, Grand Rapids, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

12, 13, 18, 19, 20, MSMS/MPMLC Risk Management: Closed Claim Reviews (Cardiology). May 12, Sylvan Resort, Gaylord, MI. May 13, Treasure Island, Saginaw, MI. May 18, Novi Hilton, Novi, MI. May 19, WMU Regional Center, Grand Rapids, MI. May 20, MSMS Headquarters, East Lansing, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

17-18, MSMS Becoming an Exceptional Biller, Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

17-21, MSMS Medical Office Management Institute, Radisson on the Lake, Ypsilanti, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

20-21, MSMS Orientation to the Medical Office, Westin Hotel, Detroit, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

25, 26, 27, MSMS Electronic Billing: Do You Know All You Need to Know? May 25, Ritz Carlton, Dearborn, MI. May 26, Treasure Island, Saginaw, MI. May 27, Fetzer Center, Kalamazoo, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

26, MSMS Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide, Amway Grand Plaza, Grand Rapids, MI. Contact: Helen Fordham, MSMS Communications, (517) 336-5786.

27-28, MSMS Maternal Health Conference Retreat, Crystal Mountain, Thompsonville, MI. Contact: Greg Aronin, Assistan for Legislative Affairs, (517) 336-5739.

June

1, 2, MSMS Carcinoma of the Breast: A National Liability Epidemic. June 1, Novi Hilton, Novi, MI. June 2, WMU Regional Center, Grand Rapids, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

1, 2, 3, MSMS Improving Your Practice Productivity and Performance in the 1990's. June 1, Troy Marriott, Troy, MI. June 2, Treasure Island, Saginaw, MI. June 3, Fetzer Center, Kalamazoo, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

8, 9, 11, MSMS Supervisory Skills Series - Part III (How to Build an Effective Office Team). June 8, Best Western Domino Farms, Ann Arbor, MI. June 9, Treasure Island, Saginaw, MI. June 11, Sylvan Resort, Gaylord, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

11-13, MSMS Financial Planning Series, Sylvan Resort, Gaylord, MI. (June 11) IFiancial Planning for Retirement and (June 12-13) Early Financial Planning for Physicians. Contact: MSMS Office of Physician Education, (517) 336-5784.

14-15, MSMS Medical Biller Training Series (Blue Cross/Blue Shield), Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

23, MSMS Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide, Grand Traverse Resort, Traverse City, MI. Contact: Helen Fordham, MSMS Communications, (517) 336-5786.

24-26, MSMS/AMA Young Physicians Series, Radisson on the Lake Ypsilanti, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

July

14-18, MSMS Midsummer Board Meeting, Shanty Creek, Bellaire, MI. William Madigan, MSMS Executive Director, (517) 336-5734.

Michigan Specialty Society Meetings

August

14-20, The Twelfth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine. Contact: Society of Magnetic Resonance in Medicine, Inc., (510) 841-1899.

AMA Meetings

June

10-17, AMA House of Delegates, Chicago, IL. Contact: Judy Marr, MSMS Manager, Department of Communications and Professional Relations, (517) 337-1351.

National Specialty Society Meetings

May

20-22, American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

October

13-17, American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

29-31, American Society of Bariatric Physicians, Westin Hotel, Chicago, Ill. Contact: (303) 779-4833.

HOSPITAL BANKRUPTCY AUCTION

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REAL ESTATE & EQUIPMENT

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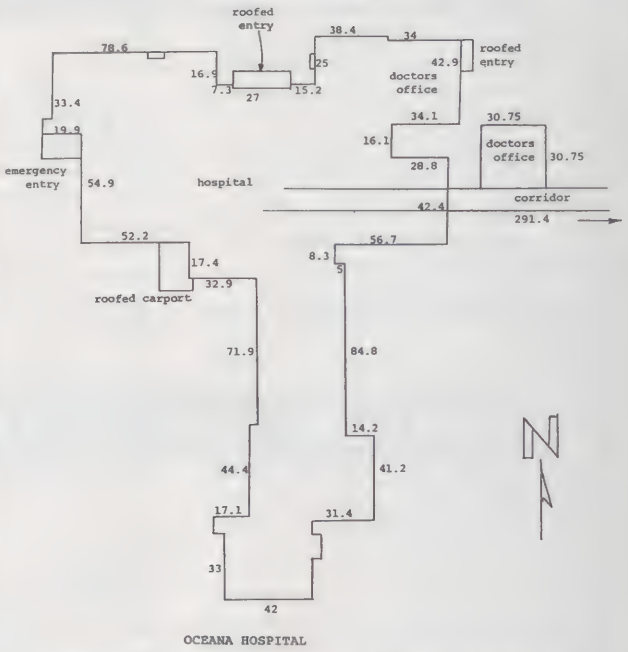
Partial Equipment Listing

- Transworld X-Ray Mammograph MAMCP 100 RAD 550 M
- Ohio Anesthesia Machine
- Market Forge SS IV Prep Station
- Nova Biomedical Blood Gas Analyzer Stat Profile 2
- Skytron O-R Table and Light
- Many other O-R Tables and Lights
- Air Shield Ventimeter
- Stryker Gurneys
- Gomco Vacuum and Drainage Pumps
- Blood Pressure Machines
- Picker Intl. EKG
- Travenol Volumetric Infusion Pumps
- Bird Port-Pulse Oximeter
- Physio-Control ECR w/ cart
- Exam Tables
- Scanlin Morris Traction Table
- Nuclear Assoc. Diagnostic Densitometer
- Image Data Photo Phone
- X-Ray Viewers
- Centrifuges
- Labline Incubator IMP II
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- IBM Typewriters
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Real Estate Info



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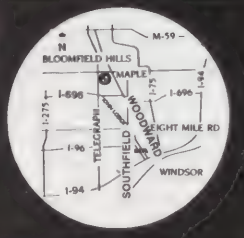
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3-oz. cooked serving of chicken breast

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3-oz. cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

Compare pork with chicken[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz. cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.[1] According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

Recommend

TODAY'S PORK

The Other White Meat®

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation:

Name: Younis Ahmad Assad, MD, P. O. Box 8628, Toledo, OH 43623
Action, Date Taken: Summary Suspension, 10-26-92
Reason: Convicted/Criminal Sexual Conduct

Name: Stuart William Bilyeu, DO, 1210 N. Maple Rd., Ann Arbor, MI 48103
Action, Date Taken: Summary Suspension, 2-4-93
Reason: Substance Abuse

Name: Stephen J. Davis, DO, 1109 Ashbury Dr., Decatur, GA 30030
Action, Date Taken: License Suspended - 6 months, Fine - $1,000
Reason: Negligence, Incompetence

Name: Dennis L. Deacon, DO, 35117 Dodge Park Rd., Sterling Heights, MI 48312
Action, Date Taken: License Revoked, 3-12-93
Reason: Substance Abuse

Name: James R. Frew, Jr, MD, 17280 Young's Lake, Big Rapids, MI 49307
Action, Date Taken: Probation - 2 years, 3-1-93
Reason: Physically/Mentally Impaired - Drup Related

Name: Felma Jimenez Fuentes, MD, 95 F Urgello Street, Cebu City, Phillipines 6000
Action, Date Taken: License Suspended - 1 year, Fined $10,000, 3-1-93
Reason: Unethical Business Practice

Name: Stephen D. Hershey, MD. 9 Alger Place, Grosse Pointe City, MI 48230
Action, Date Taken: Reinstated w/Limited License, Probation - 2 years, 11-2-92

Name: Janetta M. Kelly, MD, 4601 Treehills Parkway, Stone Mountain, GA 30088
Action, Date Taken: License Granted w/Probation until 4-3-96, on 2-19-93
Reason: Substance Abuse

Continued on following page

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

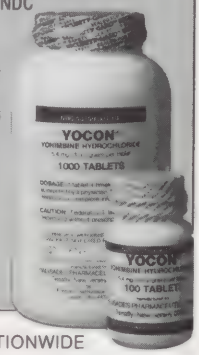
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Board of Medicine Actions

Continued from page 61

Name: Ernest G. McCampbell, MD, 3320 Spinnaker Lane, 18B, Detroit, MI 48207
Action, Date Taken: Reclassified w/Unlimited License, 11-2-92

Name: Felix K. Milton, DO, 4026 Oakwood Blvd., Melvindale, MI 48122
Action, Date Taken: Summary Suspension, 2-4-93
Reason: Drug Related

Name: Harold R. Myers, DO, 1747 Fay Street, Lowell, MI 49331
Action, Date Taken: Voluntary and Permanent Surrender of License, 12-31-92
Reason: Mental-Physical Incompetency

Name: Basil Rodansky, MD, Health Stop Medical Center, 1500 Eureka Road, Wyandotte, MI 48192
Action, Date Taken: Reprimand, Fine: $1000 - Probation, 12-2-92
Reason: CE Audit Violation

Name: Ronald E. Sanders, MD, 564 Cypress Lane, Apt. 912, Greenville, MS 38701
Action, Date Taken: License Limited, Probation - 5 years
Reason: Substance Abuse

Name: Samuel Shaheen, DO, 6000 Dixie Highway, Bridgeport, MI 48722
Action, Date Taken: Voluntary and Permanent Surrender of Drug Control License, 1-13-93
Reason: None given

Name: James M. Slater, DO, 519 Garfield St., Jackson, MI 49203
Action, Date Taken: License Revoked, Fine - $5,000, 2-6-93
Reason: Drug Related

Name: Michael J. Stanek, DO, 3520 Banyon, NW, Massillon, OH 44646
Action, Date Taken: License Limited, Probation until 9-5-95
Reason: Substance Abuse

Name: William L. VanArsdale, MD, 988 Mendon Rd., Athens, MI 49011
Action, Date Taken: License Limited - 2 years, Fine - $500, Reprimand, 2-17-93
Reason: Drug Related

Name: Peter D. Vlcko, DO, 2370 Walton Blvd., Rochester Hills, MI 48309
Action, Date Taken: Summary Suspension, 2-4-93
Reason: Negligence, Incompetence



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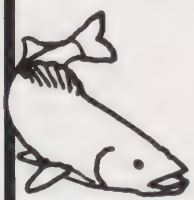
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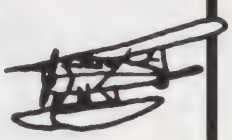
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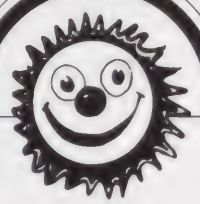
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PRESIDENT'S PAGE

Michigan's Opportunity for Tomorrow

By Gilbert B. Bluhm, MD



I am honored to serve as the new president of MSMS. I believe all of us are in for a very challenging year. Clearly, the national rush to universal health coverage opens the most exciting challenge to come before us in several decades.

Our country is on the brink of a new social adventure. If prior major social plans for social security, medicare and medicaid are any guide, this new health program will be hastily implemented and poorly funded. These are the root problems that will consume our attention in the months ahead.

Cost of programs currently in place have brought us to this threshold. It is costs that will determine the quality and depth of care to be offered to the American public. We have all worked long and hard to build a quality health care program. None of us wants to see that effort compromised.

Physicians as prime health care managers have the task to reach out to the American public – our patients. We must clearly define for them what their role is in this effort and what the bottom line impacts are. The public has to address major cost issues which drive the way we practice medicine. Nearly a third of the costs in health care today result from poor lifestyle habits. The other major health expenditure which is nearly a quarter of all expenses is related to the treatment of the terminally ill in hospital settings during the last 30 days of life.

We have a mandate to address these issues. To do that, we have to do a better job of communicating...with our patients and with those whose efforts mold the environment in which we practice. I believe we may wish to take a leaf from Ross Perot's book and give the American public a basic primer on health, just as Perot did with "political science 101" last fall.

> "Our strength is the diversity of the membership. Working together to discuss and evaluate issues, ideals and events, we can produce a strong position to confront the anticipated change of health care reform."

The physician's dilemma hasn't changed for almost a century when George Bernard Shaw characterized it succinctly: "The poor public makes a simple but unreasonable demand. They abhor illness and wish to be protected against it. But wish to be protected cheaply."

How do we help our patients, fellow citizens and our profession? We have the aptitude. We are experienced. But, it will be our attitude, not our aptitude which will be crucial. Similar elements will be necessary that were used as we approached medical liability change. Our attitude was perseverance (two decades!). We dedicated the issue to the best interest of our patients. We developed coalitions to help. We studied the facts. We learned the needs of our colleagues. We developed options. We prevailed!

Healthcare opportunities will require a similar approach. We will need to consider the difference within our family of physicians and other health providers. Our different vistas must be molded into effective policy and with unity modulate the issues for the betterment of patients and us. Our strength is the diversity of the membership. Working together to discuss and evaluate issues, ideals and events, we can produce a strong position to confront the anticipated change of health care reform. Buttress stated: "If truth can be derived, it is from the heat generated by the friction between free and friendly minds." Our task will be to keep us free and friendly!

What I've described is one of three activities I hope to promote during my tenure as MSMS president. The other two relate to a youth preventative health program and physician recruitment for a stronger MSMS. I will discuss these activities in more depth in the next two issues of *Michigan Medicine*.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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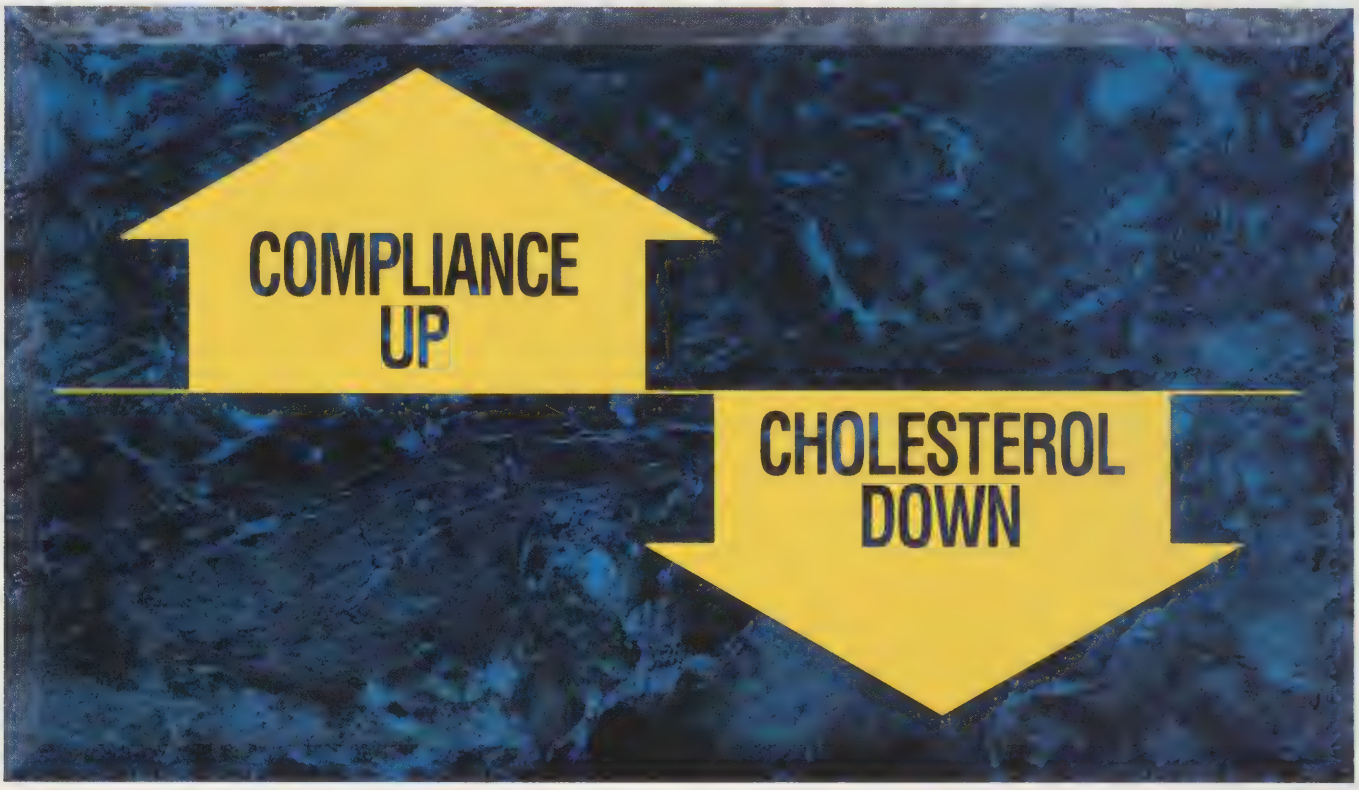
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Award-Winning Journal of the Michigan State Medical Society

Cover Story

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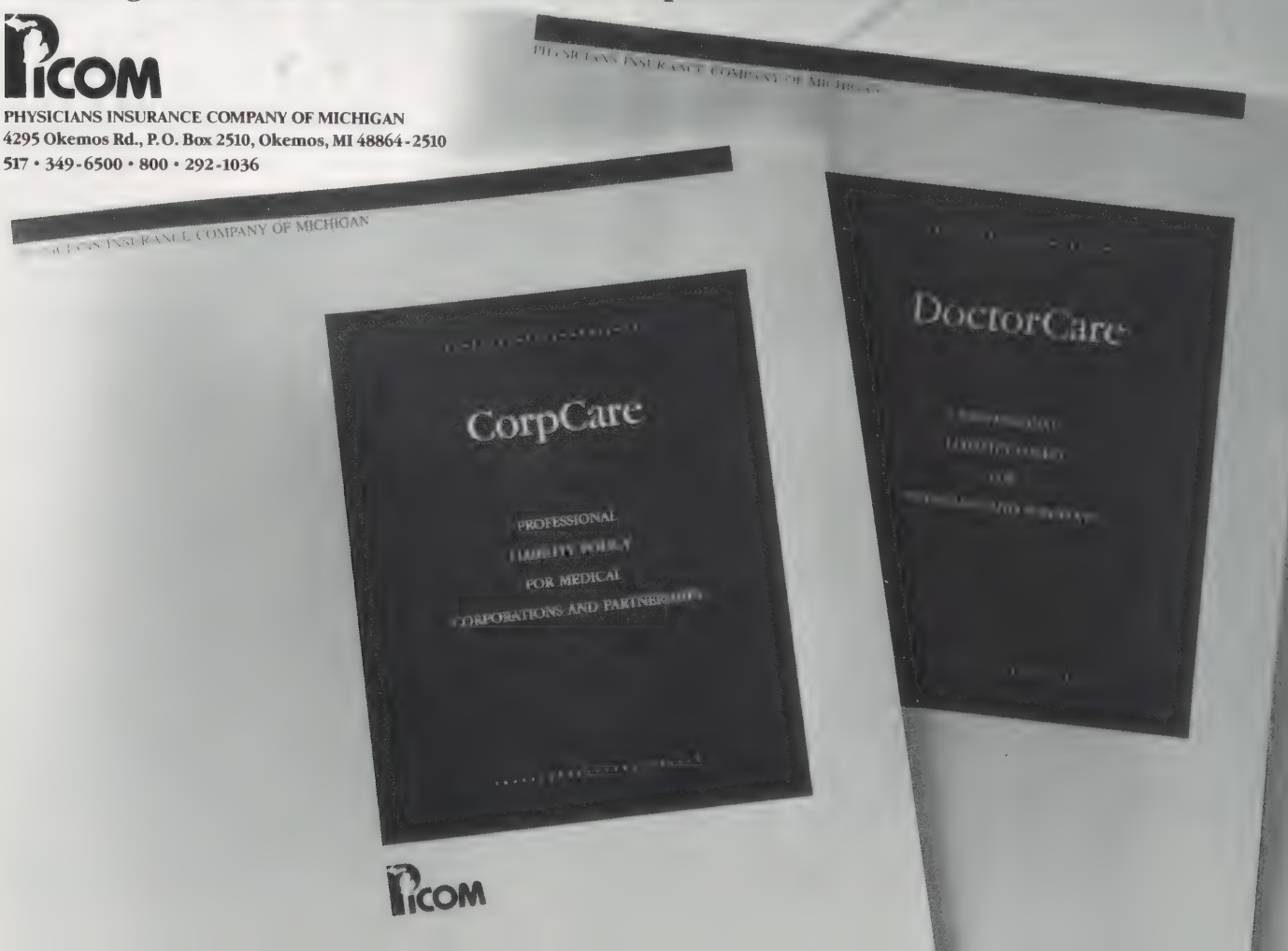
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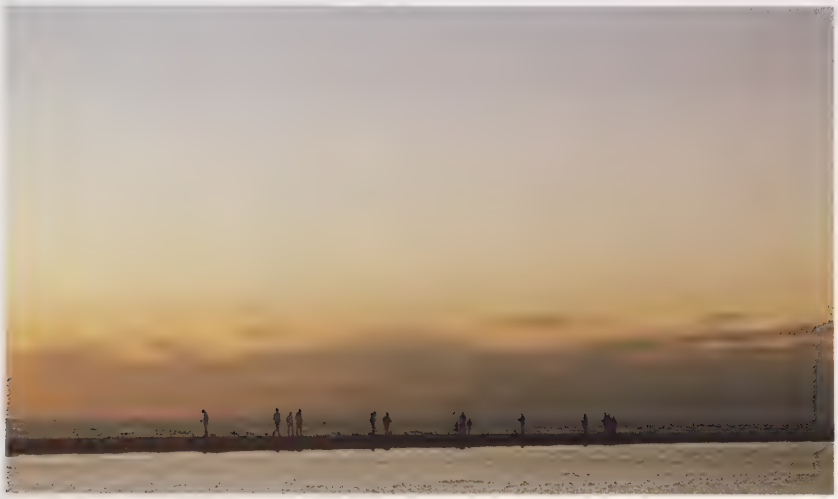
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MICHIGAN MEDICINE

JUNE 1993 VOLUME 92, NO. 6

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

MSMS recognizes the need physicians have to deal with the stress they endure on a daily basis. Last September, the MSMS Board of Directors authorized the establishment of the Task Force on Physician Well-Being. Since then, the Task Force has sponsored and co-sponsored physician well-being programs led by John-Henry Pfifferling, PhD, of the Center for Professional Well-Being in Durham, NC. All the seminars have been well received. MSMS is currently exploring the many ways it can help its members better deal with the stress in their lives. The articles in this *Michigan Medicine* cover story offer many sound and practical suggestions.



OTHER KEY ARTICLES

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Risk Management Exchange

This new *Michigan Medicine* monthly feature provides answers to your risk management questions.

By Julie Smith

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MSMS Adopts Policy Statement on Physician-Assisted Suicide

After holding 14 forums over a period of one-and-a-half years, the MSMS Committee on Bioethics issued a statement on physician-assisted suicide in February. The MSMS House of Delegates May 2 adopted that statement. The entire statement is presented here along with comments from key state leaders.

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Legal Briefs

MSMS legal counsel provides timely information on a variety of legal issues and cases including physician self-referral, state bar lobbying and the Martin Amicus Brief.

By Richard D. Weber

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Delta Dental Open Enrollment

June is Delta Dental Open Enrollment. See this article for important details.

By Valerie Barker

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Medicare's New E&M Codes

This article indicates Michigan physicians are doing "a good job" of utilizing these new Medicare codes.

By George R. Gerber, MD

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In next month's issue:

Advances in Medical Technology

Cover Design: *By Robert Brent*

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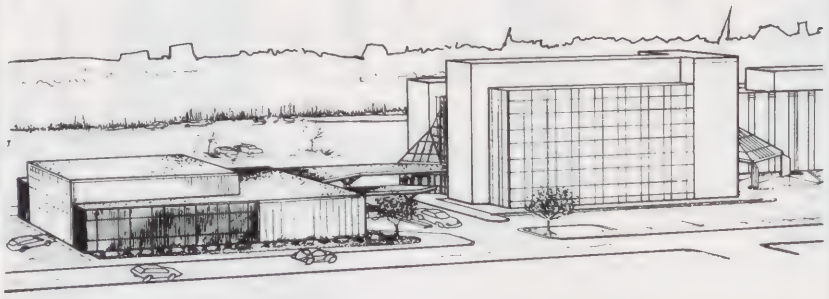
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Michigan Medicine (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published once each month, 12 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $100.00 (includes weekly *Medigram* newsletter); single copies, $3.00: Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news and exchanges should be addressed to Betty McNerney, advertising to Pat Horan, and address changes to Kathy Hagen, Michigan State Medical Society, P.O. Box 950, East Lansing, Michigan 48826-0950. Phone 517-337-1351.

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MSMS ON THE MOVE

A monthly update of key MSMS activities

MSMS sets summer workshops to prepare for health care reform

MSMS is planning 10 statewide seminars this summer to provide expert guidance for doctors on forming physician organizations (POs) and physician hospital organizations (PHOs). They'll build on a spring conference conducted May 20 by the MSMS Physician Organizations Committee. During that conference, doctors talking about PO/PHO formation in several Michigan communities heard from medical and legal experts on how to go about it.

MSMS will draw on these experts to provide information during its half-day summer workshops. These sessions will be held:

June 23/Lansing
June 28/Grand Rapids
July 13/Detroit
July 21/Traverse City
July 23/Marquette
July 27/Flint
August 4/Kalamazoo
August 11/Ann Arbor
August 17/Saginaw
August 26/Troy

Call the MSMS Office of Physician Education at (517) 336-5784 for more details. A conference titled "POs/PHOs: Cornerstone to Successful Health Care Reform" will be held Sept. 10-11 at the Embassy Suites hotel in Southfield. Spring conference participants and other physicians will be invited. They, in turn, will invite hospital administrators, hospital board members and other interested health care professionals to attend with them to spur further discussion on PO and PHO formation. Call Tom Plasman at (517) 336-5724 or Tom Wolff at (517) 336-5740 for information.

Information in MSMS CLIA booklet helps physicians

MSMS has prepared an in-depth summary of CLIA regulations to assist doctors with compliance. It contains information on fees, sanctions, inspections and proficiency testing. The cost to MSMS members is $10.00 per copy, and nonmember cost is $30 per copy. Call Tom Wolff at (517) 336-5740 to order your copy.

MSMS seeks nominees for Board of Medicine openings

Five slots on the 14-member Michigan Board of Medicine will open in December when terms for those members expire. Members are appointed by Gov. Engler, and MSMS has been asked to provide recommendations on nominees for his consideration. Four positions will be new appointments and one will be a reappointment. MSMS urges interested physicians to submit their curriculum vitae to MSMS as soon as possible. Nominees will be selected by the MSMS Board of Directors at its midsummer meeting in July. Call Greg Aronin at MSMS at (517) 336-5739 for details.

For details on these and other issues call William E. Madigan, Executive Director, MSMS 517/337-1351.

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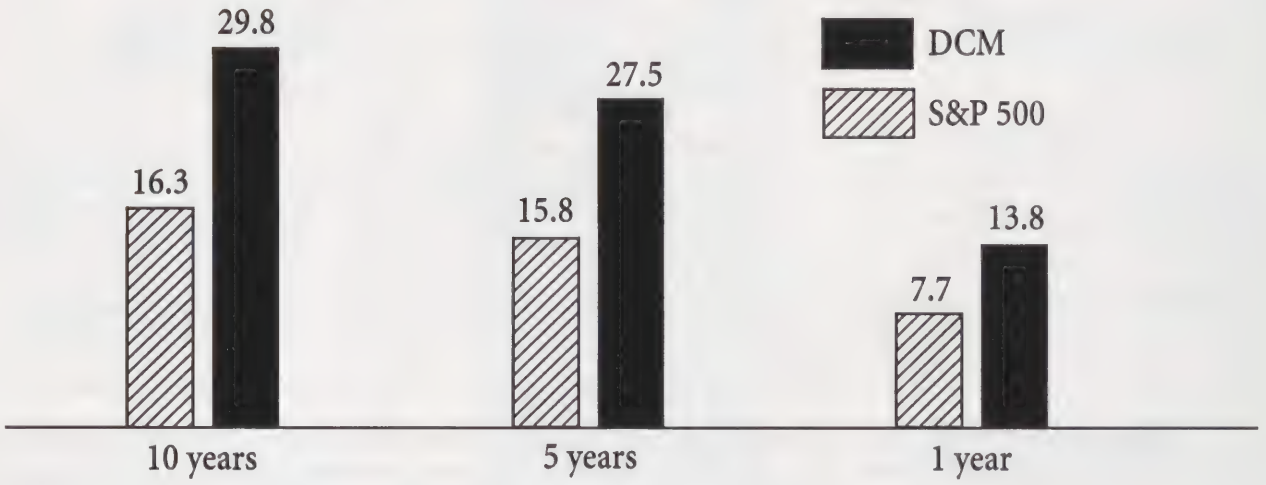
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LETTERS

Michigan Medicine "worth emulating"

I'm impressed with your magazine. It's a quality publication. Many states have made the transition from scientific to socio-economic, but none with the class of your journal. The articles are timely and exceptionally well done. A good job ...worth emulating.

David Bickham
Executive Director
Oklahoma State Medical Association

Articles on informed consent before HIV testing raise more questions than answers

The articles in the April 1993 issue of *Michigan Medicine* on the pros and cons of written informed consent before HIV testing raise more questions than answers.

Doctor Davis (medical director of the Michigan Department of Public Health) states that both the Michigan Association for Local Public Health and the Michigan Association of Public Health Physicians favor continuation of mandatory informed consent. As a member of both organizations (I can say) this is not the unanimous opinion of the members of these organizations; there is considerable dissent.

None of the five reasons that Doctor Davis lists for not changing the law have any medical or disease prevention base, nor does any of the eight given by the Michigan Association for Local Public Health. The reasons listed are either political or social.

No one has ever died from testing for HIV infection. No one was ever discriminated against for testing negative for HIV infection. From my experience, the discrimination against persons who test positive for HIV is largely fiction and much less than a person with active Tuberculosis. A person who tests positive for HIV has had the ultimate discrimination, they are doomed to be infected with HIV until the day they die of AIDs. Nothing can alter this fact.

The value of case finding and contact tracing has been proven by time and experience. The emphasis for medicine and public health must be in protecting the uninfected.

Testing for HIV should be done at every contact with a health provider. No additional lives will be lost, and a great many deaths can be prevented.

Medicine and Public Health's only concerns should be disease prevention

Continued on page 11

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Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

Compare pork with chicken[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz, cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.[1] According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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LETTERS

Continued from page 9

and saving lives. The political issues should be left to the politicians and the social issues to the social workers.

J. Maxwell Cook, MD, MPH
Medical Director
Branch-Hillsdale-St. Joseph
District Health Department

"Rules of life" key to improving adolescent health

I read with interest the article in the March 1993 issue of *Michigan Medicine* that discussed MSMS President-Elect Gilbert B. Bluhm, MD, and his involvement with educational efforts designed to improve adolescent health. While I applaud his efforts, I would like to add an admonition: along with the education add the "rules" of life. As a nation we tend to shy away from rules, but as a result we find ourselves without a common moral basis, a condition which will ultimately lead to anarchy if left unchecked.

Nicholas Eberstadt in an editorial in the January 20, 1993, edition of *The Wall Street Journal* discussed education and the role it plays in solving the infant mortality problem. "Education can be highly effective when lack of knowledge is a constraint; it fares less well when the problem is a lack of motivation."

The *Detroit Free Press* on March 31, 1993, had an article by Jane Gross that chronicled gang rapes by high school boys in California to earn "points." A quote from Eric, one of the leaders, is particularly telling. "They pass out condoms, teach sex education and pregnancy-this and pregnancy-that. But they don't teach us any rules." Interestingly, the remainder of the article never tried to address this kid's quandary.

Where do we find the correct rules? I would propose that the only rules which have stood the test of time are those set forth by God in the true Bible. Many would say that Christianity has been tried and failed. I would say that it has been tried and found too difficult. None the less, it is the only true moral imperative. Even if one does not believe in the God who wrote the rules, one can at least acknowledge that these rules have some transcendent logic that work for the good of all men.

So what am I trying to say? Doctor Bluhm's effort is laudable and needs to be done, but without the "rules" it will no more contribute to the long-term health of our nation's children than did all the sandbags and boarded-up windows in stopping the onslaught of hurricane Andrew.

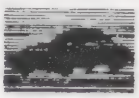
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At present, experts at The James are investigating and administering visionary cancer therapies such as intraoperative radiation therapy (IORT), brachytherapy, taxol, 13-cis retinoic acid and numerous other therapies on patients from over 23 states and 2 foreign countries.

INTRAOPERATIVE RADIATION THERAPY

IORT, performed during surgery, utilizes targeted radiation to reduce or eliminate tumors without penetrating overlying tissue or damaging noncancerous cells surrounding the tumor. At The James, IORT is administered in a specialized operating suite equipped with a linear accelerator capable of emitting six million to 18 million electron volts. During treatment, a circular cone is positioned on the tumor and laser beams are used to align the accelerator before the prescribed high dose of radiation is applied. A minimum of 70 patients annually will be treated in the IORT suite.



BRACHYTHERAPY

Brachytherapy, or radiation implantation, destroys cancer cells by delivering radiation directly to a tumor. Radiation oncologists place radioactive material inside or in close proximity to the tumor so that a very high dose of radiation can be delivered to the tumor with little of the radiation going to the healthy tissues around the tumor. Because healthy tissue remains undamaged, side effects are usually minimal.

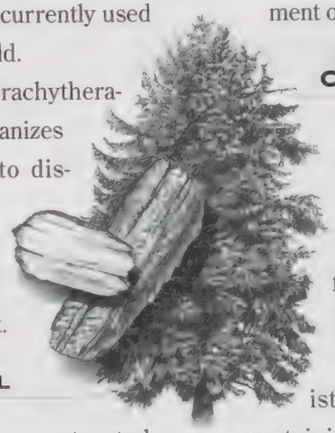
The James, one of the leading proponents of brachytherapy, actively applies several forms of brachytherapy for various cancers and is one of the few centers to implant young children.



Early methods of brachytherapy often required surgery and lengthy hospitalization and exposed patients' families and nursing staff to radiation. Researchers at The James are spearheading efforts on several fronts to overcome these problems. High dose rate brachytherapy allows the treatments to be given in a few minutes on an outpatient basis while totally eliminating radiation exposure to the medical staff. Fluoroscopy and ultrasound can be used to guide the needles into tumors without requiring surgery to expose the tumor. The researchers at The James have combined the advantages of IORT and brachytherapy to deliver intraoperative high dose rate remote brachytherapy to tumors normally inaccessible to either IORT or brachytherapy.

Radioimmunoguided brachytherapy utilizes a hand held instrument that can detect the radioactive material remaining in small tumors yet not visible to the surgeon. A critical innovation in cancer treatment, the instrument was developed at OSU and is currently used throughout the world.

The Section of Brachytherapy at The James organizes annual symposia to disseminate the latest information on this emerging oncology treatment.



TAXOL

The James has now treated patients from eleven states with taxol under a special National Cancer Institute Compassionate Use Program for patients with advanced ovarian cancer. In all, more than 54 patients have been treated at The James, the site of Ohio's only NCI-designated Comprehensive Cancer Center. This experimental treatment uses the scarce anti-cancer drug taxol, currently derived from the bark of the Pacific Yew tree. The taxol program at The James is designed only for women who have previously failed other treatment regimens and who have progressive disease. Other protocols using taxol in first line treatment are also available.

The Comprehensive Cancer Center is currently one of three centers in the United States using taxol in the treatment of breast cancer, and one of only two centers using taxol in the treatment of head and neck cancer.

BORON NEUTRON CAPTURE THERAPY

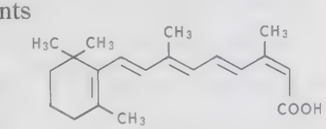
Boron neutron capture therapy, which might offer significant promise for treating brain tumors, was first proposed by Dr. William Sweet in the 1950's.

Following the administration of delivery agents containing boron-10, the tumor is then irradiated with neutrons, resulting in a nuclear fission reaction yielding high energy radiation (alpha particles in Lithium-7 nuclei). A team of researchers at the Comprehensive Cancer Center is attempting to develop different boron delivery systems that will deliver amounts of boron to the tumor large enough to be effective. Researchers are also working in other aspects of BNCT, including the development of models to test therapeutic efficacy, alternative neutron sources and clinical treatment planning.

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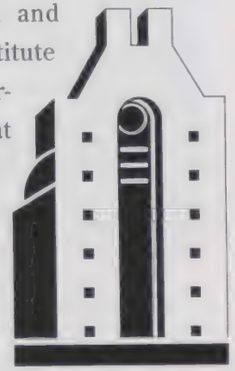
A seven-year study of 13-cis retinoic acid currently is underway to test the effectiveness of prolonged low-dose 13-cis retinoic acid in reducing the risk of second primary tumors in patients who have had head and neck cancer which has been controlled by surgery and/or radiotherapy. In addition, researchers are evaluating the kind and number of toxicities of low-dose 13-cis retinoic acid administered daily for three years.



{ 13-*cis* Retinoic Acid }

PROGRESS AND POSSIBILITIES

Every day, tremendous strides are being made on many cancer fronts. Yet, it's a long way until total eradication of this ancient malady is achieved. However, the symbiotic relationship between research and treatment at The Arthur G. James Cancer Hospital and Research Institute forms a powerful wedge that is continually forcing the door open a little wider in the search for a cure.



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Good medical records key

to prevention, defense against malpractice claims

By Julie Smith

A good medical record is the physician's best means of prevention and defense against malpractice claims. A thorough medical record facilitates optimal communication between all individuals involved in the patient's care and ultimately acts to prevent the occurrence of treatment-related errors. When a plaintiff's attorney initially reviews a record to determine the potential for a claim against a physician, he/she attempts to identify evidence to support liability on the part of the physician. The attorney will attempt to identify, through the documentation - or lack of documentation - that there was a breach in the standard of care, an injury to the patient, and a causal link between the two.

Frequently, the decision to defend or settle a claim is based on the quality of the documentation in the medical record. If the care provided is not adequately documented, it can be perceived that it did not occur. The record, therefore, will provide the physician with little support in defense and, in fact, may adversely affect the physician's credibility.

Q How long must I keep my medical records?

A There is no legal requirement in the state of Michigan for how long after the last patient encounter a physician must maintain a medical record from a private medical office. Common sense and expectations of when this record will again be necessary should dictate medical record retention policy.

While **forever** is the best retention policy from a risk management standpoint, it is often impossible and impractical. *Generally, seven to 10 years from the last patient encounter is a sufficient length of time to retain most medical office records.* However, it is advisable that records of pediatric or obstetric patients be maintained until the minor has reached the age of majority. For patients who encountered complications during treatment, it is advisable that these records be kept for longer lengths of time.

Federal regulations mandate that hospital medical records be maintained for five years, and Michigan law requires that medical records of nursing home patients be maintained for six years following the date of discharge. Destruction should be accomplished by shredding or incineration, thereby leaving no information available to contribute to a damaging breach of confidentiality. This would constitute a breach of the physician-patient relationship and could expose the physician to liability. Patients often assume their records will be kept "forever." Therefore, it is advisable to notify or attempt to notify them before the record is destroyed and provide them with the opportunity to retrieve a copy of the record or to have it transferred to another practitioner. It is also advisable to document your efforts to notify the patient.

Q How do I document an adverse event/outcome which was or could be construed as a "mistake?"

A Following a situation which resulted or is likely to result in an adverse outcome, the information committed to the medical record is crucial to the ultimate ability to utilize the medical record for defense of a claim or lawsuit. In lawsuits, medical records can be admitted into evidence to prove or defend against liability.

Medical record entries should contain factual information but not assumptions as to the cause of or reason for the problem and judgements as to potential liability. In addition, the only information which should be documented is that which pertains to the care provided. For example, it is not advisable to record the fact that "you forgot" to call the patient about her abnormal mammogram performed six months prior.

Never attempt to alter or falsify the record. The destruction, alteration, or falsification of a medical record for the purpose of concealing responsibility for a patient's injury is a felony punishable by imprisonment and fine. In addition, if such acts are discovered, and the chance for

discovery is high, the credibility of the record and your verbal testimony would be severely damaged in a civil action. Avoid documenting information related to legal actions taken, such as notified insurance company or contacted risk manager.

Prior to writing the record, it is important to carefully think through what you plan to write. If it involves a very complicated situation, it may be helpful to "sketch out" the entry first on scrap paper which is then discarded appropriately.

Q Am I obligated to forward copies of a patient's medical record to another physician if the patient's account has an outstanding balance?

A The actual physical record is the property of the physician, professional corporation or institution. *The information contained in the record "belongs" to the patient, and they have a right to access this information as necessary or desired.* Upon receipt of a patient's written consent, a **copy** of the medical record should be forwarded as requested. A reasonable fee can be charged for the expenses associated with copying and mailing, but *payment of charges related to treatment cannot be a condition of releasing this information.*

Remember the information contained in the record is confidential and must be protected from unauthorized disclosure. Before releasing a copy of the record to another provider or other source, authorization from the patient is required, preferably in writing and signed by the patient, and proof of this authorization should be maintained in the patient's record.

Julie Smith is chief of risk management for MSMS.

Michigan Medicine is pleased to introduce "Risk Management Exchange" - a new monthly feature which offers answers to physicians' questions about risk management. All questions and answers are reviewed by MSMS legal counsel, Richard D. Weber, of Kerr, Russell & Weber, Detroit, prior to publication. If you would like to submit questions for publication in this new feature, contact Julie Smith at MSMS (517) 336-5757.

Practice Parameters Seminars

MSMS/MPMLC joint section on risk management will conduct a practice parameter session October 12 at the Novi Hilton discussing the importance of parameters in National Health Care Reform, successful development of parameters and the project recently implemented in Maine where established guidelines can be used for affirmative defense.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

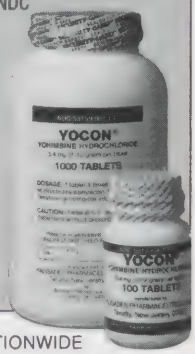
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Physician Well-Being:

Take steps to ease the stress in your life

By Carl F. Hammerstrom, Jr., MD

There's no question, physicians lead stressful lives. Day-in and day-out we tend to the needs of our patients. And, as time will allow, to the needs of our loved ones. Rarely, if ever, do we find the time – not to mention the energy, courage and support of others – to take care of ourselves. We all experience feelings of grief, failure and disappointment. Yet, few of us have the bravery to confront these feelings, let alone talk about them with a colleague.

First and foremost, we physicians must realize that we are people, just like our patients and loved ones, that we have feelings, and yes, *limitations*. As much as we'd like to be, we can't be all things to all people.

As chairman of the recently-established MSMS Task Force on Physician Well-Being, I am happy to tell you that your state medical society recognizes the need we physicians have to deal with the stress we endure on a daily basis.

Last September, the MSMS Board of Directors authorized the establishment of the MSMS Task Force on Physician Well-Being. Since then, the Task Force has sponsored and co-sponsored physician well-being programs led by John-Henry Pfifferling, PhD, of the Center for Professional Well-Being in Durham, NC. Topics of discussion have been "The Joys of Medicine," "Professional Self-Care Appraisal," "Things I Wish They Had Taught Me In Medical School," "Reclaiming the Joy of Medicine To Avoid Physician Burn Out," "Assets of a Healthy Practice," "Partnership Characteristics," "Medical Marriage," and "The Physician Image: How Do You Communicate Caring?" All the seminars have been well received.

MSMS is currently exploring the many ways it can help its members better deal with the stress in their lives. The articles in this *Michigan Medicine* cover story offer many sound and practical suggestions.

Included in this cover story is an indepth article by John-Henry Pfifferling, PhD, on how to cope with the stresses of practice. From setting life priorities to learning how to say "no" and feel good about it, Pfifferling shows us the many steps we can take to ease the stress in our lives.

Also included is an article by a physician who, after struggling with burnout and leaving his practice, came to terms with his inner self and returned to medicine.

I encourage you to study these articles and then decide to take steps *now* to reduce the stress in your life. You'll be glad you did.



HOW TO COPE WITH THE STRESSES OF PRACTICE

By John-Henry Pfifferling, PhD

Physicians who compromise their own quality of life affect not only themselves but their families and patients as well. Doctors are confronted daily with other people's crises. They need to control their own emotions in order to avoid the hazards of emotional overload -- such as chemical dependency. In the following article John-Henry Pfifferling, PhD, director, Center for Professional Well-Being, Durham, NC, offers some practical behaviors that can reduce physician distress and help to promote an enhanced quality of life. Doctor Pfifferling's suggestions are based on the results of his study of over 1,200 physicians, all of whom suffered great losses as a result of medical pressures.

One dramatic insight we have gained during our 18 years of study is derived from our experiences debriefing over 1,200 physicians who "lost" their practices, their marriages, their families, their credibility, and their self-esteem. They were asked, "Now that you have become a distressed (or "impaired") physician, what do you wish you would have learned in residency or medical school training?" The following synthesizes some of their insights.

Setting life priorities

Our physician informants uniformly felt that, often, they were responding to so many different masters that they didn't know what was really important. The habits learned by following a lock-step curriculum, where faculty told you what to do, and why, became deeply ingrained. Peer pressure reinforced maximal complaints but minimal actions. Students who questioned such methods often were negatively sanctioned by faculty and peers. Medical responsibilities took so much time that discussion of priorities was discounted. Reflective perspectives on the educational design, goals, outcomes, and style of learning was taboo. Delayed adolescence continued, so personal priority-setting - a maturity trait - was considered insignificant. Doing for others - patients, faculty, residents - was everything. Each rotation had its own ground rules for "success" and each rule had to be learned very quickly. Satisfying your own needs and being consistent with your own priorities often was impossible or was treated as seditious.

Constructing your own priorities, validating them with those you consider personally important, and acting on them so you build morale and self-esteem is essential (see sidebar).

The importance of being your own best friend

When you ask counselors of physicians how they feel about themselves, they routinely respond by describing a population permeated by internal conversations of self-doubt and unhappiness. If your internal conversations are frequently punctuated by a grammar of self-distrust, how can you really be comfortable? More importantly, how can you maintain self-esteem in the face of uncertainty and ambiguity?

If we can learn to nurture ourselves, appreciate our internal coach (the dialogue that is always available), we will find a perpetual goldmine. The world still will be unfair, but we can respond, be resilient, and challenge life's promptings. When your internal "best-friend" is acknowledged, you have an untapped well of energy and resilience. You rarely need external entertainment and are not beholden to external responses to be reassured of your worthiness. When no one else encourages you, there always is an encouraging coach (your own best friend).

The importance of comfortable alone time

Because so many "shoulds" permeate physician behavior, it's a miracle if you ever are able to find a psychologically hardy, balanced, happy physician. Their lives often are ruled by doing for others: being with, comforting, satisfying, diagnosing, treating, turfing, and triaging; time for self is nonexistent.

After you have been "othered out" all day, you then return to the needs and demands of your family. Because you "gave it all at the office," there is precious little time left for you. Our physicians repeatedly told us that they wished they had spent more time being comfortable alone - not needing anyone else and enjoying their solitude.

Continued on following page

How can physicians balance their personal priorities and their professional roles?

"Physicians can practice being less perfectionistic," says John-Henry Pfifferling, PhD. "They can tell themselves that the role of God is already filled. Physicians must recognize they are human. According to malpractice attorneys, even juries don't expect physicians to be perfect.

"It's difficult for doctors to go from being what I call an MDeity to being a non-authoritarian spouse and parent at home. But physicians may find the transition easier if they look to their spouses and kids as a comfort, a first line of defense against professional stress. Doctors should think of themselves as a composite of various roles, with the role of physician holding an important, but not all-consuming role."

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The importance of vacations

We often fantasize a brand name for a luggage line called "guilt." We could make a fortune just selling it to general internists, and we could even have separate sizes for heavier and lighter journals that they plan to read on their "vacation."

Vacations are times for rest, relaxation, revitalization, exploration, growth and curiosity. Why do so many physicians try to design vacations which offer them an opportunity to catch up on their journal reading? Instead of being free on vacation, they are competing with family demands to be available and the guilt of unread journals.

If you wish to read journals, do so as part of your organized continuing medical education schedule, a priority that should be built into your regular schedule. Read journal articles relevant to the deficiencies of your practice or the needs of your patient load. If you are a generalist, decide where you can find the best review articles on specialties that your refer to regularly, or ask your specialists to give you feedback from their observations of your appropriate use of their skills.

Decide what the goals of your vacation are and don't bring work-related material to a non-work-related environment.

Sensuality and sexuality

Our informants are very clear about sexual and sensual issues. Physicians, by ego, societal image, and patient expectations, are the objects of a tremendous amount of projection. When your own sexual needs are unmet, you are vulnerable to those of your patients who project unrealistic images on you concerning their sexual needs. A vulnerable host and a vulnerable agent often create a disease state.

Learn to understand your needs. Learn to satisfy and articulate your needs to a loving person. Hear their needs and listen to their relationship priorities. Work to reduce your anger from unmet needs. The risks associated with practicing medicine include the occupational hazards of vulnerable and projecting patients.

The consequences of overwork

Physicians who want to feel needed and who unrealistically "enjoy" the strokes from helping and rescuing others often please "mercilessly." There is always more work than is possible for you ever to do in the human services professions. If you do not allow others to make mistakes, they can never grow independently. Overwork enables others to use you instead of their own self-reliance. Overwork enables your family to make excuses as to why you are unavailable when they need you. They also maintain the baggage of resentment. Overwork maximizes your use of defensive rationalization and reduces your ability to let go, surrender, and be at peace.

Overwork and your "needed" status allow you to rationalize the use of chemical coping — uppers to give you energy and downers to calm you after your overwork binge. Overwork is a wonderful excuse to run away from your stated priorities to your family, community, and friends. Overwork almost always is a metaphor for insecurity and poor management skills.

Physician addicts can regale you for hours about their use of "overwork" as an excuse to prevent them from reaching out for needed help. What are your primary priorities? Who can help you to deliver quality care to those who realistically can be cared for with your energy and resources?

Grief, failure and disappointment

Recovering physicians have shared with us a litany of unprocessed grief, failure, and disappointment that led them to depressive and chemical coping. Grief is an inevitable part of the medical profession. It must be processed and requires time and nurturance. Failure is an inevitable hazard of practicing the art of medicine under the guise of scientific knowledge. The patient who presents to your office has not been followed in a double-blind, randomized, crossover study, and chances are, he or she never will be. Your office practice is a constant onslaught of magic, mystery, science, clinical intuition, and reasonable interventions.

Dispppointments are inevitable. Work to share your disappointments with peers, staff, and patients. Develop a communication system so your patients learn to treat you as a person first with medicine as your special interest.

Things I Wish They Had Taught Me in Training

1. Setting life priorities.
2. The importance of being my own best friend.
3. The importance of comfortable alone-time.
4. The importance of vacations.
5. Dealing with sensuality and sexuality.
6. The consequences of overwork.
7. Dealing with grief, failure and disappointment.
8. How to appropriately share my feelings.
9. How to say, "I don't know."
10. How to let go of shoulds and of my need to rescue.
11. How to say no and still feel good.
12. How to leave my work at the office.
13. The dangers of self-medication.

Disappointments are occupational hazards of medical human science. They will routinely drain you of energy unless you schedule re-energizing routines into your life. Otherwise, you are playing "MDeity." Remember, that role is filled.

How to share your feelings appropriately

Medical practice is an emotional roller coaster. One day of an intern's life has more tragedy and drama than the average layperson experiences in a lifetime! The second day is even worse because, characteristically, interns don't sleep.

The accumulating emotional responses to catastrophe, questionable decisions, idiosyncratic dose responses, real healing, and real failures are inordinately taxing to your spirit. The culture of medicine hides, chides, and discounts the aggregating unprocessed feelings of practitioners and residents. Emotional distancing is rewarded. "Real doctors" don't respond to the wellsprings of their hearts as they are tugged and pulled on a daily basis. Where and to whom do you turn if your colleagues aren't there when you need them? How do you remain resilient when your feelings are rubbed raw and you are supposed to deny them.

Once a resident "saw" another resident sob quietly in the dim light of the NICU. When the observing resident tried to comfort her peer, he vehemently denied the actual scene.

Our physicians emphasized the importance of regularly sharing the feelings experienced by each of us as we give of ourselves in medical practice. Join a self-care group of physicians (or other helping professionals) who support each other. Establish ground rules for what you expect to accomplish and start and end at scheduled times. But allow the processing of medical grief, failure, ecstasy, and joy.

How to say, "I don't know"

If we could change one behavior in all of the key figures who socialize student physicians, who intimidate, criticize, and reward, we would change the penalties applied to students who say, "I don't know." Faculty who deprecate the learner's most natural phrase reward deceit. Students who don't allow faculty to say, "I don't know," contribute to a system of distrust and gamesmanship.

The most relaxed phrase for most of us, most of our lives, can be "I don't know," unless we have learned to become defensive about our inability to know everything. As knowledge inexorably increases, we need to learn together, cooperatively, and in a nondefensive environment.

How to let go of "shoulds" and your need to rescue

Our physicians felt that by letting go of oughts and shoulds they could purge an entire generation of defensive and uptight colleagues. Applying "oughts" to most situations disallows you from accepting the reality of the present. We often ask our physician students to collect a dollar for every encounter in which their partners used the word "should." When they caught themselves using the word "should" in their own internal dialogue, they put a dollar in their unconditional bank account because they were growing healthier. Most shoulds are metaphors for someone else telling you how to act when he does not have access to the facts you have in the situation. *Be wary of shoulds and oughts – they often carry excess baggage (guilt).*

If you are unwilling to let go of old messages and old shoulds, you spend your energy struggling to hold on to the past instead of dealing with the present. You may become so caught up in recalling the rules that you can't deal with the problem in its present context.

If you can't give up old goals in the face of present data, you may guarantee failure. Your self-fulfilling prophecy will become actualized, and you will lose in the present.

Surrendering or "letting go" skills allow you to focus on the present. Use the best of what you have right now, without self-doubt, self-criticism, and self-destruction before you have even attempted to deal with the situation.

Letting go allows you to share responsibilities with others instead of shouldering the entire burden yourself. A surfeit of "should" behavior guarantees that you will have to make many more mistakes than are necessary. Accept your unfinished tasks as well as the finished tasks. If everything was finished, you would be dead!

Constructing Your Priorities

Ask yourself regularly:

- ☐ What are the really important issues, themes, and commitments in my life?
- ☐ What do I have to jettison if I am to be true to my priorities?
- ☐ How good do I really feel when I know my priorities and I stand up for them?

How do you say "no" and still feel good?

Physicians in our sample felt that they were unable to say "no" and still feel good. They were so caught up in trying to please that they became everything to everybody. They said so many "yeses," that they literally lost their freedom. Then they had to satisfy all the commitments they agreed to – which, of course, was impossible.

Others around them had so little respect for them that they asked them for more since they gave themselves away so easily. A pattern of nonrespect became a self-fulfilling prophecy and they began to believe they were really losers. What a terrible tragedy.

Learning to say no is practicing assertiveness. Assertiveness is saying what you mean. Regularly saying "yes" when you really mean "no" builds up resentment and

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Work Life Appraisal Checklist for Physicians

Instructions: *Check the following items that you perceive to be factors in your work environment.*

- ☐ 1. Repetitive work with little or no variety.
- ☐ 2. Unrealistic scheduling resulting in continuously high stress with few breaks to unwind or "depressurize."
- ☐ 3. Inadequate resources to perform job.
- ☐ 4. "I'm rarely told that I've done a good job and that I am appreciated."
- ☐ 5. Lack of opportunity to air work-related feelings.
- ☐ 6. "I feel that I'm poorly matched for my position, and no effort exists for correcting this situation."
- ☐ 7. "I was given appropriate instruction in what my job entails including letting me know about the most common job stressors."
- ☐ 8. "I feel isolated from other people in the office."
- ☐ 9. "The reality of my job greatly differs from what I expected."
- ☐ 10. "I perceive my company/hospital and my position to have a negative public image."
- ☐ 11. "I am too involved in my job to the detriment of my family and other aspects of my life."
- ☐ 12. The organization/work group changes either too frequently or too slowly to be effective.
- ☐ 13. Clear job descriptions, organizational goals, and policy manuals do not exist, or are often not used.
- ☐ 14. Little attention is paid as a team to making short- or long-range goals or plans.
- ☐ 15. Little reward is given for improving delegation of responsibility and authority.
- ☐ 16. Orientation programs and training are relevant and regularly re-evaluated for appropriateness.
- ☐ 17. Regular attention is paid to the comfort, safety, and ergonometric needs of staff/faculty/professionals.
- ☐ 18. Staff needs for privacy are addressed.
- ☐ 19. Divergent views and suggestions are tolerated and systematically solicited.
- ☐ 20. Career planning and life/work planning are available as a fringe benefit.
- ☐ 21. A non-stigmatizing program for troubled employees/professionals is available.

Commentary

The results of this checklist give concerned managers two valuable insights: (1) a quick review of the most common factors that may be in their control, and (2) immediate insight into the most highly contagious factors promoting burnout.

Features in the work environment that contribute to burnout include:

Cognitive and emotional perceptions

"Do I have any control over the environment, the variety of work, potential overload and its significance?"

Physical

"Do I have any control over noise, light, space, and structural discomfort?"

Socio-political

"Do I have any input into the numbers, severity of problems of those who receive my services?"

"Bureaupathological"

"To what extent can I participate in setting the rules and policies that concern red tape, paperwork, communication problems?"

"How much role confusion, conflict, and prestige ambiguity is in my organization?"

The single most powerful ambient contributor to individual work-related distress is the perception of the workplace as non-caring. Any employee who feels "alone" will often carry these self-distress perceptions as an added weight. These "burdens" are incompatible with creative energy and creativity is stifled.

Regular discussion of work stressors that prove that "I am not alone" are healthy. They also reduce the tendency of professionals to internalize and reinforce a self-critical attitude. Preventing the harmful consequences of burnout requires attention, vigilance, and a proactive stance.

Source: Center for Professional Well-Being

Continued from page 19

anger. The cumulative buildup of resentment is a causal factor in stress-related diseases. If you often please others by saying "yes" when you really mean "no" you are automatically satisfying others' needs and neglecting your own. When you neglect your own needs, painful feelings ensue. If they are not discharged in an appropriate fashion, you aggravate stress diseases.

The most common request we receive in our clinical practice of physicians is, "Teach me how to say no."

You must have a reasonable amount of self-respect and self-esteem in order to say no graciously. What kind of self-respect do you really have? Aren't you ultimately responsible for your own well-being? Once you give an answer to someone else they must live with the consequences.

Practice assertive responses: "I really would be comfortable doing that or "I really would not be comfortable doing that." "I appreciate your asking me to be on that committee, but my personal priorities make it impossible this year."

How do you leave your work at the office?

Our recovering stressed-out physicians almost uniformly had a difficult time disengaging from their professional ego. Their self-respect seemed attached to how well they thought they performed as physicians. Other roles they played in life were discounted in favor of ego feedback as a physician. They had a hard time leaving the office because their needs for feeling indispensible were predicated on being a physician.

In other roles - father, mother, neighbor, community member, etc. - they perceived themselves dispensible. As physicians, their command over unknown forces (pathogens, disease agents, prognoses, and diagnoses) was almost total compared with their patients.' As more competition occurs in the practice of medicine, some traditional status, authority, and needs will change.

Physicians are rewarded in their training for using their "left brain." So when they need to develop rationalizations for why they are needed at work, they are superb. Their non-medical associations, spouses, children, and even friends, can barely compete with the urgency of the medical role. Emergencies and urgencies do arise at unpredictable times and "only I really know the patient" becomes an often-used excuse.

Another common rationalization, although with some degree of truth, that stopped our physicians from leaving their work at the office was: "My role as physician is a calling not just work; I always need to be available to my patients." Of course, when no one else can take care of patients as well as you can, no one else has the opportunity to ply the trade, make mistakes, and grow. *Lots of devilish rationalizations support the continuing attachment to work.*

How does one compete with someone who may have just saved a life, prevented the loss of a limb, or prescribed the appropriate life-giving medication? On the other hand, resentment by children, spouses, friends and family builds inexorably when your priorities appear to be everyone but the role/relationship you have with them. *Our recovering physicians are learning to leave their work at the office, to delegate appropriately, share call, and teach their patients when it is appropriate to call the physician.*

The dangers of self medication

The recovering chemically dependent physicians shared numerous stories of how they fooled themselves into self-medication. Their rationalizations were remarkably believable. "I used drugs because I had to be awake for a 12-hour operation" or "My medical stress was so great, living between boredom and panic, that I needed to

Continued on following page

PEDESTAL-ECTOMIES

John-Henry Pfifferling, PhD, has dedicated his life to helping physicians through...

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calm down to sleep" were common refrains. "I was the only physician for the entire county, so I had to be awake" was another one.

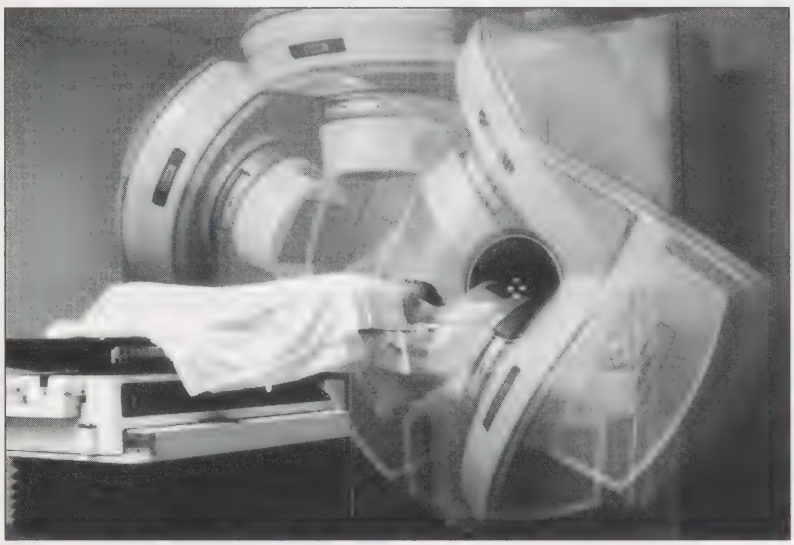
These physicians often received medication on the run, in hospital hallways, or from office supplies, with no quality control of appropriate use. They self-diagnosed and, when they were in doubt, were fearful of telling their colleagues that they may have made a mistake. They had access to the "candy store of immediate gratification" for physical and emotional pain, and they believed that chemical coping and abuse could not happen to them. "Somehow, I am immune to pharmacological side-effects because I memorized Goodman and Gilman," was a common rationalization.

The pecking order of medicine so often placed the general practitioner, family physician, general internist, or pediatrician at the bottom that they received the most difficult and chronic of patients. Being pleasers, they, in turn, accepted and passively resented this. How often have we heard the comment, "Society doesn't pay for caring or listening, it only pays for procedures."

Physicians are people first, and medicine is their special interest. They, too, need emotional support, nurturance, empathy, and regular revitalization. When they don't know how to reach out for natural energy renewal, chemical coping becomes an easy way out. They have grown up in a culture that sanctifies the instant cure. They have received more advertising on the benefits of medications than any proportionate group, except for pharmacists. Finally, their training has been woefully deficient in non-chemical coping skills. Where these were taught, they often were chastized for learning nontechnical "soft stuff."

To prevent and reduce the epidemic of drug use and misuse among medical students and physicians, we need role models who are thriving practitioners who enjoy medicine without drug interventions. We also need students who are proficient in the knowledge base of substance abuse medicine – a specialty in its own right. We need students who have learned about the risks of chemical coping by adult children of alcoholics/dysfunctional families. They need experience in learning the behavioral skills of neutralizing the hazards of being a codependent.

Breast-Conservation Treatment



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PHYSICIANS ARE PEOPLE TOO

A story of one physician's struggle with his inner self

By Helen Fordham

Editor's note: The following story describes the experience of one physician who, after struggling with burnout and leaving the medical profession, comes to terms with his inner self, accepts his limitations, and returns to medicine. His identity has been concealed.

Five years ago, Nigel Smyth, MD, (not his real name) was at his sister's baby shower – a happy occasion where everyone was excited at the prospect of a new life. Yet all Doctor Smyth could think about was a patient he'd seen that morning – a patient who, though suffering from hepatitis, cirrhosis of the liver and cerebral atrophy, was still denying his alcoholism.

It was not the first time Doctor Smyth had obsessed over a patient. Earlier that year he had gone to a luxurious resort with a close friend and had spent the entire four days worrying about an infection in a patient's knee.

These two occasions coupled with innumerable others, gradually forced Doctor Smyth to realize that – just two years out of his internal medicine residency – he was in crisis.

"It wasn't a single event that made me realize I was burned out," confides Doctor Smyth. "But every time something went wrong with my patients I blamed myself."

His constant worry about work was showing in other ways. He worked 16-hour days and couldn't sleep or eat. Already a thin man, he lost 20 pounds. The self abuse went further. He was living in a bad part of town in an apartment that had no heat and was infested with rats. "I was so absorbed in my work I didn't have time to take care of myself," he admits.

Realizing he was burned out, Doctor Smyth made the decision to leave medicine. Having no family responsibilities made such a choice easier for him to make. He announced the decision to his colleagues in group practice and to his surprise received their support. "I was not made to feel ashamed of this decision," he says, "in fact some of the others were envious.

> "We are insecure human beings, who are scared of being wrong and making a mistake. We are just people, but society doesn't look upon us like that ... Physicians need to rediscover a sense of community, mutual support and learn to help each other."

Change needed from within

He decided to enroll in graduate school to complete a research degree in microbiology. He wanted to stay in the laboratory, away from the stress of dealing with patients. Yet, while in school he came to realize that what he needed to change was himself and his approach to his work, not his environment.

A self-professed workaholic, he began to spend time with others who had similarly addictive behavior traits. He joined a 12-step recovery program and came to accept his limitations.

Doctor Smyth learned that he couldn't please everyone and that he wasn't responsible for everyone. "I realized that I'm not God and I'm not perfect," he explains. "I'm human and I make mistakes."

Yet medicine tends to attract individuals who have impossibly high expectations of themselves, says Doctor Smyth. "My profession is filled with people-pleasers who do so at the expense of their own health and the health of their families."

Doctor Smyth explains what he thinks is the psychology behind this behavior. "Doctors are other-ated," he says. "We get our self esteem from others. We externalize. Someone says 'thank you' and we can go a million miles on it." This desire for approval, however, makes physicians vulnerable to the expectations of others. Doctor Smyth found this to be true in his own case. "I went into medicine," he explains, "because I thought there would be an emotional reward for solving everyone else's problems." Looking back he realizes his approach was immature. "I figured if I took care of others then everything would fall into place," he says. "It didn't because I didn't take responsibility for myself."

As a result of the 12-step program, Doctor Smyth discovered he couldn't solve everyones' problems, he could just do his best.

Not an easy lesson to learn

Not all physicians, however, learn such a lesson. Doctor Smyth knows a lot of physicians who are burned out. He sees



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Continued from page 23

the tell tale signs of depression, divorce and substance abuse. "We don't see a lot of understanding from the culture," he says.

When Doctor Smyth says "culture" he is referring to both society at large, which depicts physicians as greedy, selfish and money grubbing, and to the medical establishment itself, which Doctor Smith sees as dysfunctional.

"We are insecure human beings, who are scared of being wrong and making a mistake," Doctor Smyth admits. We are just people, he adds, but society doesn't look upon us like that. We are asked to fill a role we can't, he said, and so we live a lie trying to accommodate what society expects of us.

According to Doctor Smyth, the structure of the medical establishment exacerbates this situation.

"Physicians suffer from denial, isolation, a macho feeling which makes them think they can fix everything, and a hopeless feeling that nothing will get better. So they keep plodding along," he explains.

Relationship healing essential

In order to address these feelings Doctor Smyth sees a need for a lot of relationship healing among physicians. "The profession needs to get healthier," he says. "Physicians need to rediscover a sense of community, mutual support. We need to learn to help each other." Yet, according to Doctor Smyth, this is made more difficult because physicians as a whole do not honor their feelings. Physicians need to learn to talk about emotional discomfort, he adds, and they need to learn how to say no. In 1991, Doctor Smyth joined the Society for Professional Well-Being run by John-Henry Pfifferling, PhD. Having gone through the experience, he resonated with what Pfifferling had to say about wounded healers and the need to take better care of themselves. Doctor Smyth hopes well-being programs currently being implemented in Michigan will make medicine a healthier place. He would like to see physicians excited about practicing medicine and rediscovering a sense of community and balance in their lives.

"Medicine may get healthier, it may not," he says. "It depends on each individual physician - but we don't have to do it alone."

Doctor Smyth has since returned to medicine. He feels he has found his own balance. "I did permanent damage," he admits. "Now an alarm goes off when I start abusing myself again."

He works regular hours and has learned to take care of sick people while still living a life of his own. "I've learned a bit more about letting go of patients," he says. He has bought a nice home, takes vacations and attends meetings that remind him of what he can and can't do, that he is not alone and that he is not God.

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Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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PROGRAM AGENDA

■ **The National Health Care Reform Proposal.**
An overview of the Clinton Administration's health system reform proposal. What are the key provisions and their implications for physicians? What is the AMA's legislative strategy? What can you do to help? *Presented by representatives from the American Medical Association.*

■ **State Health Care Reform Initiatives.**
Up-to-date information on state health care reform initiatives and how you could be affected if these plans are adopted. *Presented by representatives from the Michigan State Medical Society.*

■ **Models of Successful Private Sector Organizations.**
A discussion of the latest developments in private sector initiated managed care organizations and their implications for Michigan physicians, this will include an analysis of the developments regarding Blue Cross Blue Shield's Community Care Partnership and other point-of-service plans. *Presented by MSMS Legal Counsel, Kerr, Russell & Weber .*

■ **POs/PHOs: Their Organization, Development and Operation.**
Information on the potential advantages of physician organizations (POs) and physician-hospital organizations (PHOs) as a strategy to retain maximum control over the clinical aspects of medicine, while taking advantage of expanding opportunities for managed care contracting. *Presented by physicians and other representatives who have organized, developed and administered a PO/PHO.*

■ **What's Happening Today, in My Own Community?**
The program also will provide an opportunity for attendees to discuss the organizational efforts that have been initiated in their own communities, and their impact on the local medical practice environment. *Led by members of the MSMS Physician Organizations Committee.*

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SPECIAL REPORT

MSMS Adopts Policy Statement on Physician-Assisted Suicide

After holding 14 forums over a period of one-and-a-half years, the MSMS Committee on Bioethics last February issued a statement on physician-assisted suicide. That statement, adopted by the MSMS House of Delegates May 2, outlines nine points of committee consensus on this controversial issue.

Although the public policy debate that has grown around physician-assisted suicide over the past several years suggests the desirability of a clear organizational position, there is no consensus on the ultimate question: "Is physician-assisted suicide ever an allowable part of the physician/patient relationship?" Nevertheless, MSMS feels that the lack of consensus of its Committee on Bioethics reflects the diversity of opinion among Michigan physicians. For that reason, the MSMS Committee on Bioethics prepared a three-part report. The report first outlines nine points of consensus upon which all members agree. The second and third parts were prepared separately by members of the Committee who either opposed PAS or who felt that PAS was possibly a part of the physician/patient relationship. Beyond the discussion on PAS, the Committee recognizes the need for renewed professional efforts on behalf of patients suffering with terminal or incurable long-term illnesses.

Following is the MSMS-adopted statement on physician-assisted suicide.

Definitions

Three terms used to discuss the role of physicians in the deaths of patients require definition so as to avoid confusion regarding the scope of this statement.

"Allowing a patient to die," refers to discontinuing or withholding life-prolonging medical procedures or treatments when requested or consented to by the competent patient or by the appropriate advocate for the incompetent patient. (Example: A patient bleeding from an advanced malignancy requests no further blood transfusions or intravenous fluids. The physician orders these modalities discontinued and morphine administered for pain. The patient dies six hours later.)

"Physician-assisted suicide," refers to the physician providing the patient with a substance or device with the understanding that the patient intends to use those means to cause his or her own death. (Example: A patient with advanced malignancy, who has an indwelling intravenous line, wishes to die because of his weakness and inability to care for himself. At the patient's request, the physician supplies a syringe with 500 milligrams of morphine, which the patient uses at a later time to inject and bring about his own death.)

"Active euthanasia," refers to the physician administering the means to cause death to the patient directly, intending that death will occur. (Example: A patient with advanced malignancy, who has an indwelling intravenous line, wishes to die because of his weakness and inability to care for himself. At the patient's request, the physician injects 500 milligrams of morphine into the intravenous line, and the patient dies.)

Allowing a patient to die is ethically and legally acceptable and is indeed mandatory in many cases. Active euthanasia violates laws against homicide, although voluntary euthanasia within strict guidelines is advocated by a thoughtful minority of physicians. This statement does not deal further with those two categories.

Points of Consensus

All members of the MSMS Committee on Bioethics agree with the following statements:

1. The medical profession in Michigan should strive to provide the following strategies to enhance patient control over the dying process:

a) improved pain and symptom control;

b) assurance of the right to competent treatment refusal; and

c) utilization of advance directives (written and verbal).

Full utilization and emphasis on the above may reduce the number of patients expressing an interest in assistance in suicide.

2. Providing a patient with sufficient medications to relieve pain even if it ends up shortening life, is neither assisting a suicide nor performing active euthanasia. Such provision is an essential of compassionate care.

3. The so-called "right to die," i.e., **right** to refuse unwanted or burdensome medical treatment, does not extend to or embrace a **right** to die with a physician's assistance (through assisted suicide or active euthanasia).

4. A physician should never suggest or recommend suicide to a patient. The medical profession should not create nor allow a practice or specialty focused on or limited to assisting in suicide nor the development of specialized facilities for effecting assisted suicide. These could have the effect of advocating assisted suicide as a preferred or routine option.

5. Even if there are theoretical arguments which deny the existence of morally relevant differences among allowing a patient to die, assisting a patient's suicide and active euthanasia, there are strong prudential and clinical reasons to maintain these distinctions as a matter of policy.

6. A patient's mention of an intent or desire to commit suicide, or of a request for assistance, should result in a concerted effort to ascertain and ameliorate any factors contributing to the patient's suffering.

7. The physician's reluctance to assist in or to cause the death of a patient is rooted in the very basic principles of professional integrity having to do with healing and relief of suffering for the purposes of extending the life of the patient. Only the most pressing circumstances, if any at all, can justify abandoning this position.

8. Legal prohibition of (physician) assisted suicide would be difficult if not impossible to enforce, and it is likely to have undesirable effects upon medical practice.

9. Societal changes to improve the quality of life and the perceived value of the life of the ill and/or elderly and to eliminate the financial barriers to medical (including hospice and comprehensive long term) care may serve to limit patient requests for assisted suicide.

Summary of Opinions in Opposition to Physician-Assisted Suicide

Opinions in opposition to physician-assisted suicide can be conveniently grouped under several headings: professional, legal, natural law, and religion.

Professional. For centuries the practice of medicine has been guided by the Hippocratic Code of Ethics, which expressly prohibits assisted suicide, despite the many changes that have occurred in treatment.

The physician has been perceived by the public, and likewise has perceived himself or herself, as a healer – not as an agent of death or executioner.

Permissibility of physician-assisted suicide would inevitably change that perception, and adversely effect the patient/physician bond of trust.

Permissibility would eventually lead to a new specialty of "Doctors of Death;" would make the physician a tool of the patient; and would tend to lead to a subtle, albeit unintentional, coercion of the non-life-threatened disabled to request assistance in suicide.

Physician-assisted suicide is foreign to the intent and tradition of medicine. Lastly, no set of criteria could encompass all gray areas, and would only invite legal scrutiny and legislation.

Legal. The law in general favors preservation of life, and only in very restricted circumstances and after extensive court proceedings, sanctions the taking of life.

Natural Law. Suicide is per se unnatural, being contrary to the innate instinct toward survival, not toward self-destruction.

Religion. Many religions consider suicide to be immoral, whether assisted or not.

Conclusion

While some might envisage some circumstances when some assistance in dying would seem humane and justified, *physician-assisted suicide is foreign to the practice of good medicine and a rejection of medical ethics that have stood the test of time. For these reasons, MSMS should strongly oppose physician assisted suicide.*

Summary of Opinions in Support of Permissible Physician-Assisted Suicide

The ongoing, personal relationship between patient and physician is a critical moral feature of medical ethics. After persistent attempts to find treatments and supports for a suffering patient, there are times when such attempts fail to result in a quality of life tolerable to the patient and the patient spontaneously expresses a desire or intent to commit suicide and requests assistance from the physician so as to achieve a peaceful death. Providing the means for the patient to commit suicide in these extraordinary circumstances is permissible under the ethical principles that physicians relieve suffering and not abandon patients. Thus, there could be occasions when conscientious physicians acting within the scope of good medical practice could provide patients with means to end their lives. For this reason, MSMS should not categorically oppose physician-assisted suicide.

Assistance in suicide is not a right of the patient and therefore physicians have no duty (obligation) to assist in suicide. If the physician and patient reach consensus that there are no other acceptable options, and if it is consistent with the physician's personal values, it is permissible for the physician to provide means for the patient to commit suicide. If such assistance is not acceptable to the physician, the physician must inform the patient and continue all efforts to relieve pain and suffering.

The physician providing means for suicide to the patient must document the following:

a) confirmation of the diagnosis and prognosis, with appropriate consultations;
b) options for continued treatment which have been offered (tried or refused) to the patient;
c) patient origin of the request for assistance in suicide;
d) physician attempts to assure that the request was truly voluntary (by assessing for coercion) and that the request was consistent over a reasonable period of time (days, not weeks or months); and
e) the means which were provided to the patient.

Out of respect for the privacy of individuals, health records should not be public, even when the patient chooses assisted suicide. The recorded cause of death should be the underlying illness. On the other hand, regulations pertaining to medical examiners should provide for review of the circumstances surrounding death in instances when physician-assisted suicide is utilized. With appropriate documentation as outlined above, physicians assisting in suicide should not be subject to legal liability. If appropriate documentation is lacking, cases should be submitted to immediate review to identify possible inappropriate or illegal activity. Medical examiners should submit summary data to the state regarding all cases of physician-assisted suicide for inclusion in a central case registry for professional and/or public review. Review of such data can assure adherence to guidelines and assess for evidence of discrimination against members of any vulnerable populations.

Committee Chair speaks out on MSMS policy statement



"I want to try to emphasize that this is a very positive statement. Though it has no single position, this symbolizes the deep division within the medical community on physician-assisted suicide. It's both more honest and informative to produce a divided statement. It's also very impressive that we agreed on a number of important points, particularly on compassionate care for the terminally ill. I see this as a strong statement on our commitment to care."

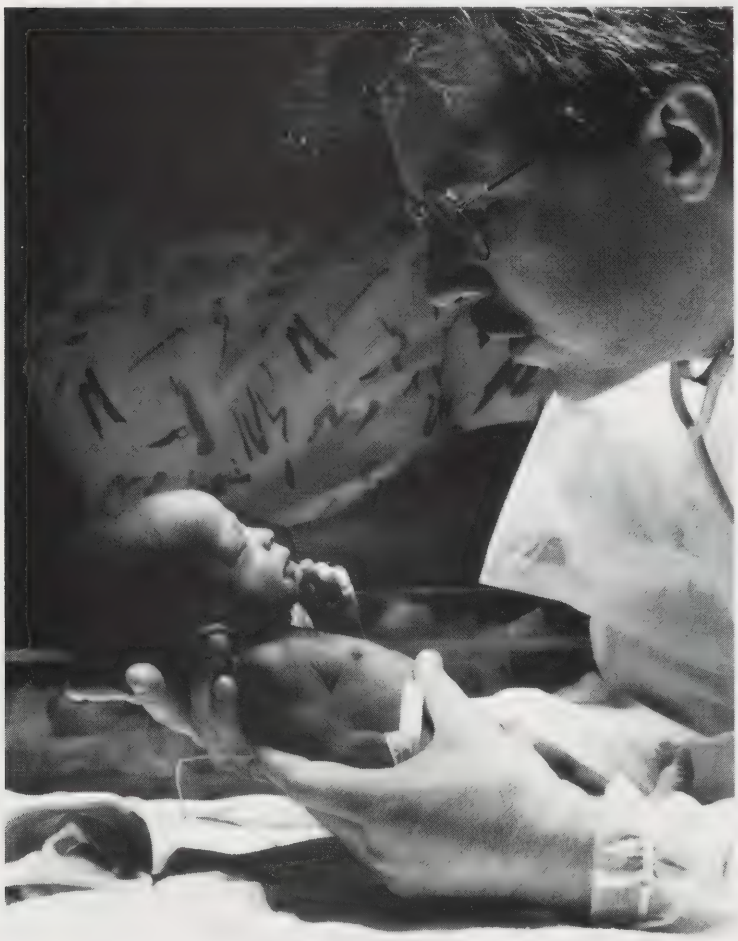
Howard Brody, MD, Chair, MSMS Committee on Bioethics

State Establishes Commission on Death and Dying

State officials in May released the names of the 22-member Michigan Commission on Death and Dying. The task force has 15 months to look at the issue of assisted suicide and report back to the state legislature.

As spelled out in the assisted suicide law, each of 22 groups can name a member and alternate. The members and the groups they represent are:

Robert Aranosian, *Michigan Association for Retarded Citizens.*
Wanda Baad, *Health Care Association of Michigan.*
Howard Brody, MD, and Thomas C. Payne, MD, *Michigan State Medical Society.*
Margaret Campbell, *Michigan Nurses Association.*
Charles Clark, *Michigan Psychological Association.*
Penny Crawley, *Michigan Council for Independent Living.*
Deborah Cummings, *National Association of Social Workers.*
Jane Friedman, *American Civil Liberties Union of Michigan.*
Janet Good, *Hemlock Society of Michigan.*
Marie Iverson, *Citizens for Better Care.*
Judeth Newham Javorek, *Michigan Hospital Association.*
Dianne Kempen, *Michigan Head Injury Survivor's Council.*
Lamar King, *Michigan Senior Advocates Council.*
Linda Logsdon, MD, *Michigan Psychiatric Society.*
Mable Meites, *American Association of Retired Persons.*
Kenneth Morris, *Michigan Association of Suicidology.*
John O'Hair, *State Bar of Michigan.*
Augustine Perrotta, DO, *Michigan Association of Osteopathic Physicians and Surgeons.*
Ed Rivet, *Right to Life of Michigan.*
Thomas Schindler, *Michigan Non-Profit Homes Association.*
Patrick Shannon, *Prosecuting Attorneys Association of Michigan.*
Sue Wierengo, *Michigan Hospice Organization.*



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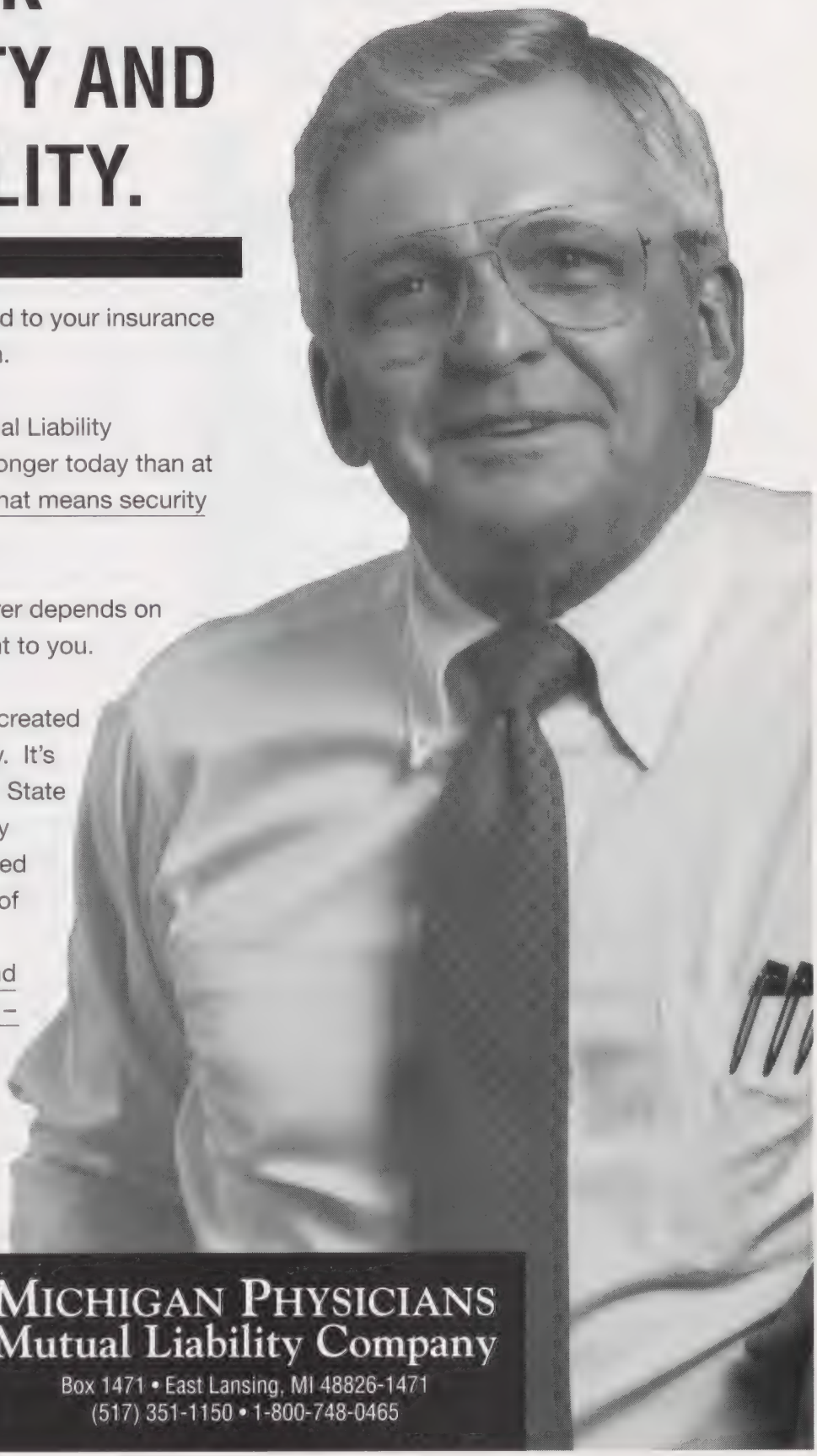
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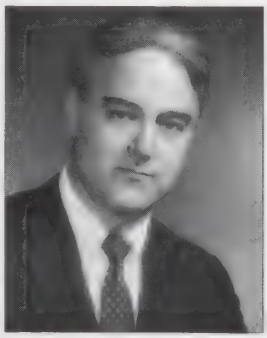
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MSMS LEGAL BRIEFS



By Richard D. Weber

The following information is provided by MSMS legal counsel, Richard D. Weber, of Kerr, Russell & Weber, Detroit. If you have a legal question you would like answered in this column, jot it down and send it to Betty McNerney at MSMS.

Physician Self-Referrals

Section 16221 of the Public Health Code prohibits physicians and other health care licensees from "directing or requiring" their patients to obtain "a drug, device, treatment, procedure or service from other person, place, facility or business" in which the licensee has a "financial interest." The Board of Medicine, following an opinion from the Michigan Attorney General, ruled that this provision precludes a physician from "referring" a patient to another facility in which the physician has a financial interest, notwithstanding full disclosure to the patient of the financial interest and options of other facilities. The Oakland County Circuit Court reversed the Board of Medicine but the Michigan Court of Appeals subsequently reversed the trial court and remanded the case for further consideration. On April 14, 1993, Judge Barry Howard again reversed the Board's ruling, holding that it (i) was the result of a substantial error of law through an erroneous interpretation of "directing and requiring"; (ii) constituted an abuse of the Board's discretion; and (iii) was in violation of the Michigan Constitution and that the ruling would result in the "directing and requiring" language being unconstitutionally vague.

The Attorney General may again appeal to the Michigan Court of Appeals, and there can be no reliable prediction as to the outcome. In the meantime, it is possible that the Department of Commerce (formerly the Department of Licensing and Regulation) will interpret Section 16221 consistent with the recent decision of the Oakland County Circuit Court.

Under federal law, such self-referrals to clinical labs are precluded. Proposed federal legislation (H.R. 345) would expand this mandate to all payors with a number of exceptions which include services provided by or under the personal supervision of the referring physician or another physician in the same practice, in-office ancillary services, publicly traded entities with assets exceeding $100 million, services provided by a rural entity and services provided by a hospital where the referring physician is a member of the medical staff and owns an interest in the hospital as a whole.

The Council on Ethical and Judicial Affairs of the AMA revisited this question last year and concluded that, in general, physicians should not refer patients to facilities outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility. The AMA ethical pronouncement would exclude circumstances where there is a demonstrated need in the community for the facility and alternative financing is not available.

Balance Billing

State statutes banning balance billing continue to proliferate. Michigan now bans balance billing in the workers comp and automobile no-fault areas. Legal challenges to state legislation banning balance billing in the Medicare context have been unsuccessful in other jurisdictions. On April 15, 1993, a New York appeals court upheld a state law limiting Medicare balance billing in that state. The Medical Society of the State of New York argued that previous law banning balance billing should not apply since HHS changed payment methodology from one based on reasonable charges to one based on the Medicare resource-based relative value scale. The New York Supreme Court, in reversing the lower appellate court, held that the change in methodology to calculate reimbursement does not render the New York law unenforceable. In September 1992, the US Court of Appeals for the Second Circuit also found this New York statute to be valid and not preempted by the Medicare Act.

BCBSM Provider Class Plan Appeal

The Michigan Court of Appeals heard oral arguments on the appeal of the ruling of Judge Borsos relative to the BCBSM Provider Class Plan. Judges Holbrook, Sawyer and White

Continued on following page

Continued from page 33

(substituting for Judge Gribbs) heard the arguments and will decide the case. Questions from the judges to both sides seemed to be evenly matched and a number of questions related to the issue of remanding the case to the Insurance Commissioner. Although a remand is a distinct possibility, no accurate prediction as to the court's ruling or its timing can be made at this time. The only prediction that may be accurate is that the Supreme Court of Michigan will ultimately be asked to decide the case.

State Bar Lobbying

Forty-eight percent of Michigan attorneys "opted out" of voluntary payment for lobbying activities in their 1992-93 bar dues. This "opt out" procedure was mandated by the US Supreme Court. As a result, the State Bar Board of Commissioners recommended to the State Bar Representative Assembly to discontinue general lobbying activities. The matter came before the Representative Assembly on April 24, 1993. Following extensive debate, the matter was tabled by the Representative Assembly to an unspecified future meeting.

Martin Amicus Brief

After reviewing the transcript and briefs of the parties, it appears that the central issue is whether a surrogate can exercise an incompetent's right to refuse life-sustaining medical treatment if the patient is not terminally ill or in a persistent vegetative state. Section 2.21 of the Code of Medical Ethics of the AMA provides, in relevant part, as follows: "Unless it is clearly established that the patient is terminally ill or permanently unconscious, a physician should not be deterred from appropriately aggressive treatment of a patient." The MSMS amicus brief will not take a position on the facts relative to Mr. Martin's medical condition. In view of the disputed facts and the AMA ethics, the MSMS amicus brief will not be directed to the issue as to whether or not terminal illness, permanent unconsciousness or a persistent vegetative state is necessary for a surrogate to act. The MSMS brief will focus on the secondary issue as to whether or not a surrogate's authority must be in writing, such as the durable power of attorney. We will vigorously argue that, although a writing is evidence, its absence should not in and of itself preclude a surrogate from exercising rights on behalf of the patient under the substituted judgement standard enunciated in the *Rosebush* decision.

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MSMS Group Insurance Trust

Invites member participation

By Valerie Barker

June has been declared "Delta" dental month by the Michigan State Medical Society Group Insurance Trust. MSMS member physicians and their employees are encouraged to join this MSMS-sponsored dental program.

Introduced in 1988, the MSMS dental program was the first-of-a-kind association-sponsored program offered by Delta. Since 1988 several hundred MSMS member physicians have enrolled. The program currently provides dental coverage to over 4,000 MSMS member physicians, family members and employees.

Affordable dental insurance is not widely available to individuals or small groups, but MSMS members have the unique advantage of choosing Delta for themselves and their employees. The Delta plan is a "free-standing" benefit. Physicians and their employees do not have to participate in any other MSMS endorsed insurance program to enroll in Delta. Access to quality benefit plans can be a real bonus, by helping physicians recruit and retain quality employees.

The MSMS Delta Plan now offers a choice of dental options. Subscribers may now choose either traditional or PPO coverage. The percentage of coverage does differ slightly between the traditional and PPO options. The Delta plan administered by the MSMS Group Insurance Trust, is billed in easy quarterly installments.

Good dental care is an important factor in good overall health. Delta's plan is designed to promote good dental care by covering all or most of all preventative procedures, depending on the plan you choose. Other procedures are covered using 50/50 cost-sharing reimbursement. See the accompanying "Delta Benefit Features Chart" which details the available options.

DENTAL BENEFIT COMPARISON

The following chart indicates the services and the percentage of coverage of the contracting dentist's usual/customary fee for the Delta traditional and PPO options.

	Traditional Delta Pays	Delta PPO Pays
DIAGNOSTIC Includes oral examinations and emergency palliative treatment.	100%	75%
PREVENTIVE Includes prophylaxes and topical applications of fluoride solutions.	100%	75%
RADIOGRAPHS As required, and in conjunction with the diagnosis of a specific condition requiring treatment.	100%	75%
ORAL SURGERY Includes extractions and other oral surgery procedures usually employed by a dentist, including pre and post-operative care.	50%	50%
RESTORATIVE Includes amalgams (silver fillings), synthetic porcelain, plastic restorations, relines and repairs to prosthetic appliances. Gold restorations, crowns and jackets may be restored with another filling material.	50%	50%
PERIODONTICS Procedures usually employed by a dentist for the treatment of diseases of the gums and supporting structures of the teeth.	50%	50%
ENDODONTICS Procedures usually employed by a dentist for the treatment of non-vital teeth (i.e., root canals).	50%	50%
PROSTHODONTICS Includes procedures required for the correction of bridges, partial and complete dentures.	50%	50%
ORTHODONTICS Treatment and procedures required for the correction of malposed teeth. Eligible persons are covered only to age 19.	50%	0%

BENEFIT MAXIMUMS

The maximum dollar amount the Delta traditional plan pays during each contract year for each covered person is $1,000. For orthodontic care, the plan pays a lifetime maximum of $1,000 for each eligible person.

The maximum dollar amount the Delta PPO plan pays during each contract year for each covered person is $800. Orthodontic care is not included in the PPO benefit plan.

Delta Dental Plan of Michigan has almost 30 years of experience in making dental care affordable and easy. Delta is Michigan's number one group dental plan. The Michigan State Medical Society is pleased Delta is its number one dental plan, too.

To learn more about the MSMS Delta plan refer to the enrollment information mailed to you recently, or call the MSMS Group Insurance Trust at 1-800-748-0195 for more information.

Valerie Barker is chief of insurance marketing, MSMS Group Insurance Trust.



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MSMS Reimbursement Roundup

By Joyce Nurenberg
MSMS REIMBURSEMENT OMBUDSMAN

Coping with Master Medical (MM)

The Master Medical (MM) Catastrophic Program extends basic BCBSM coverage or adds coverage for additional services. The program was designed to protect the subscriber against the high cost of catastrophic, unusual or long-term illness.

The program has frustrated many physicians and office staff. Primarily the difficulties have been in identifying MM contracts and collecting for services paid to the subscriber. Tracking the activity of claims within BCBSM also has been difficult because the Master Medical phone line is intended only to handle non-provider calls.

Over the last year, BCBSM has made progress to address some of the issues that physicians and staff should find helpful. Staff can determine which contracts have Master Medical benefits by using the software program Dial-In Eligibility Network Information System (DENIS), telephoning the Computer Assisted Response Environment Network (CAREN) or by referencing the newly revised Service Code Manual using the Blue Shield coverage code and looking for the MM notation.

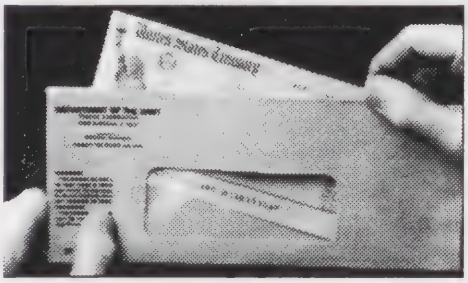
Following is the list of Master Medical benefits. This list also is contained in the BCBSM *Guide for Physicians and Medical Assistants* and on DENIS.

- Physician home and office calls (including prenatal and postnatal care)
- Allergy testing performed by a physician
- Prescription drugs (except when a patient has a BCBSM prescription drug plan)
- Prosthetic appliances

Continued on following page

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Reimbursement Roundup

Continued from page 37

- Rental or purchase of durable medical equipment
- Visiting Nurses services
- Local ambulance service (ground and air)
- Outpatient physical therapy beyond the patient's basic benefits
- Hospital days in excess of basic days for pulmonary TB, nervous and mental conditions
- Physical therapy services personally performed by a physician or a registered physical therapist.

Once a contract is identified as a MM contract, your office can proceed to collect your fee at the time of service. If your office waits until the subscriber turns over the check, be sure to record the money as a patient liability so that a monthly statement is sent out. Patients have a tendency to keep checks for bills they have not received. Unfortunately, it is a contractual obligation that the Blues remit payment to the subscriber. MSMS has asked BCBSM to investigate the potential for the subscriber to assign payment to the physician.

Also be aware every MM contract has a deductible and copay amount options so you may not always save the patient from out-of-pocket expenses. The DENIS system is available to let you know what deductible and copayments apply; however, only by patients calling the Master Medical phone line (800) 225-8100 can they determine if their deductible has been met.

Since there is no participation agreement between providers and the MM program, participating physicians are entitled to collect their full fee from the patient for services rendered. It may be wise to inform patients beforehand of this fact so that if you wait for the money, the patient includes any balance if the MM payment is less than your charge.

The approved amounts for claims submitted under Master Medical are based on actual charges which are capped at a maximum screen specific to MM. The exceptions to this are outpatient mental health care and spinal manipulation.

Since March 1992, MM services can be submitted on the Michigan Health Benefit Claim Form (MHBC). As a result, more offices are voluntarily filing claims for services on the patient's behalf. Ninety-eight percent of claims filed electronically are paid to the subscriber within 30 days. This point can help you obtain payment at the time of service because it will assure accuracy and quicker payment to the patient. If the patient does not receive payment, direct them to the MM toll-free number.

If you do not collect your money at the time of service,



"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

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agreement to submit services on the patient's behalf is now a less labor intensive task. Your offices should find that the time spent in tracking whether the services were ever submitted is reduced.

Whether you submit paper or electronically, you should follow up with the patient by phone if payment has not been received within 45-60 days. Realizing the problems that physicians continue to experience, BCBSM is evaluating avenues to allow providers access to MM information.

A section on how Master Medical situations are to be handled in your office should be part of your office policy and procedure manual to assure a consistent approach by all of your staff.

BCBSM requires physician's presence for PA services

A service performed by a licensed physician's assistant is covered when the service is:

- a covered benefit under the subscriber's contract; and
- performed under the direct and personal supervision of the physician (in the physician's presence); and
- billed by the physician.

Medicare psychiatric limit can affect more than just psychiatrists

All outpatient therapeutic psychiatric services (*90835-90899) are subject to the 62.5 percent outpatient psychiatric limitation.

Evaluation and management (E&M) services (*99201-*99353) **other than** inpatient hospital and initial diagnostic services (90801-90830) with primary diagnoses of psychiatric conditions (ICD-9-CM codes 290-319) are subject to the outpatient psychiatric limitation as well.

As a result, rather than collecting 80 percent of the approved amount from Medicare and 20 percent from the patient or secondary insurance, the percentages become 50 percent from Medicare and 50 percent from the patient or secondary insurance.

Refer to the January *Medicare Part B News* for information on interpreting the payment voucher.

The following services are not subject to the outpatient psychiatric limitation:

- Charges for **initial diagnostic services**, for example, psychiatric testing and evaluation to diagnose the patient's illness. These services include: *90801-*90830, and initial E&M services, including initial psychiatric consultations.
- **Procedure code M0064** - brief office visit for the sole purpose of monitoring or changing drug prescriptions.
- An E&M service billed with the primary diagnosis of

Continued on following page

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Reimbursement Roundup

Continued from page 39

331.0 **(Alzheimer's disease)**.

Note: An E&M service billed with a primary psychiatric diagnosis of 290-319 and with a secondary condition of 331.0 will be subject to the limitation because of the primary condition. Also, a therapeutic psychiatric service (*90835-*90899) billed with diagnosis 331.0 is subject to the limitation.

Medicare requirements for reimbursement of PA services

Services that are provided "incident to" a physician's service by a nonphysician employee are paid as if the physician had performed the service. The services, which are performed under the physi-cian's supervision, are paid under the payment schedule and billed as if the physician performed the services. HCFA has indicated that the "incident to" requirement does not always involve an encounter with the patient by the physician. According to HCFA, the requirement would be met if, during a course of treatment, "the physician performs an initial service and subsequent services of a frequency that reflect his or her active participation in and management of the course of treatment." CPT code 99211 should be reported for this level of visit.

MSMS Reimbursement Ombudsman fielded over 1,500 calls in 1992

On average, MSMS Reimbursement Ombudsman, Joyce Nurenberg, fields over 100 phone calls each month from physicians and office staff with reimbursement questions. While many of the inquiries concern Medicare, Nurenberg stands ready to offer assistance no matter which payer is involved. "Many people assume I just handle Medicare," says Nurenberg. "Actually, I can offer assistance with any of the payers."

If you have a reimbursement question for Joyce, just call (517) 336-5722.

Michigan physicians doing a "good job" of utilizing Medicare's new E & M codes

George R. Gerber, MD

"Am I doing this right?" That's the question many physicians asked back in January of 1992 when Medicare began using its new Evaluation and Management codes for services rendered to patients. Many physicians experienced a high level of discomfort when these new codes were introduced.

In an attempt to alert everyone involved in this process of their progress, or lack thereof, the Health Care Financing Administration (HCFA) provided comparative data to each carrier around the country on the use of these codes. The information was supplied for use in educational activities and programs. Comparative data showed use of the primary care codes in Michigan by specialty, and the national averages.

In general, data showed a remarkable similarity in the use of the codes between physicians in Michigan and physicians nationwide. The only abnormality found was the use of the codes describing outpatient consultations by general practitioners.

It seems that Michigan physicians are billing primarily as a mid-level service whereas nationally these services are more evenly split using all five levels of service.

I believe Michigan physicians are doing a good job at evaluating the level of service rendered and are billing appropriately when compared to their peers nationally. As time progresses, I anticipate future data will continue to show Michigan physicians in the mainstream.

As an aside, I wish to inform you that our Comparative Performance Report, sent to physicians in previous months, may be restarted in the near future. The Comparative Performance Report compares physician utilization of specific services with a peer population in the same specialty. This type of review is separate from this study, which looked only at the E and M services. These comparison studies are being used by the Health Care Financing Administration as a educational tool to heighten physician awareness of their utilization patterns.

Doctor Gerber is medical director of Medicare.

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MEETINGS

June

8, 9, 11, MSMS Supervisory Skills Series - Part III (How to Build an Effective Office Team). June 8, Best Western Domino Farms, Ann Arbor, MI. June 9, Treasure Island, Saginaw, MI. June 11, Sylvan Resort, Gaylord, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

11-13, MSMS Financial Planning Series, Sylvan Resort, Gaylord, MI. (June 11) Financial Planning for Retirement and (June 12-13) Early Financial Planning for Physicians. Contact: MSMS Office of Physician Education, (517) 336-5784.

14-15, MSMS Medical Biller Training Series (Blue Cross/Blue Shield), Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

23, MSMS Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide, Grand Traverse Resort, Traverse City, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5786.

24-26, MSMS/AMA Young Physicians Series, Radisson on the Lake Ypsilanti, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

July

14-18, MSMS Midsummer Board Meeting, Shanty Creek, Bellaire, MI. William Madigan, MSMS Executive Director, (517) 336-5734.

September

29, MSMS Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide, Holiday Inn, Flint, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5744.

October

27, MSMS Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide, Westin Hotel, Detroit, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5744.

November

9-11, MSMS Annual Scientific Meeting, Westin Hotel, Detroit, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

24, MSMS Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide, Fetzer Center, Kalamazoo, MI. Contact: Tracy Baker, MSMS Communications, (517) 336-5744.

Michigan Specialty Society Meetings

August

14-20, The Twelfth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine. Con-

Continued on page 45



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MEETINGS

Continued from page 43

tact: Society of Magnetic Resonance in Medicine, Inc., (510) 841-1899.

AMA Meetings

June

10-17, AMA House of Delegates, Chicago, IL. Contact: Judy Marr, MSMS Manager, Department of Communications and Professional Relations, (517) 337-1351.

National Specialty Society Meetings

October

13-17, American Society of Internal Medicine Leadership Development Conference, Portland, OR. Contact: Melinda Klein, (202) 835-2746, ext. 266.

29-31, American Society of Bariatric Physicians, Westin Hotel, Chicago, Ill. Contact: (303) 779-4833.

Access to Food Constitutes a Human Right



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Physicians Against World Hunger (PAWH), a non-profit, tax-exempt organization was founded so that physicians could collectively defend this human right by raising funds to support well-recognized, reputable organizations that are directly engaged in working with the poor primarily for the purpose of ending death by starvation.

Please join us — together physicians must help bring an end to world hunger.

Physicians Against World Hunger
#2 Stowe Road, Peekskill, NY 10566

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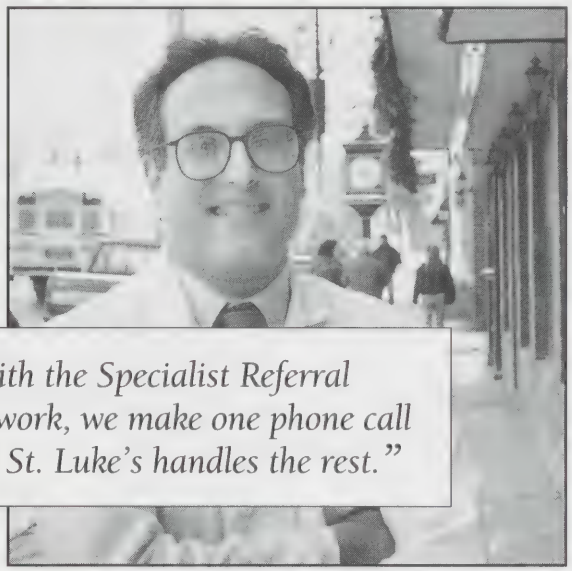
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HEALTHY RELATIONSHIPS



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Dr. William Starbird
Family Practice, North Branch

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St. Luke's Specialist Referral Network. Building healthy relationships among rural physicians, area specialists and their patients.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

June

7-10, 6th Annual Summer Conference on Aging. Location: Novi Hilton, Novi, Michigan. **Sponsor:** Wayne State University School of Medicine, Institute of Gerontology. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180.

9-11, 11th Annual Laboratory information System Symposium. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 17 hours Category I Credit.

16, Eleventh Annual Research Conference. Location: Radisson Plaza hotel at the Kalamazoo Center, Kalamazoo, Michigan. **Sponsor:** Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, MSU/KCMS, Office of CME, 1535 Gull Road, Suite 230, Kala azoo, MI 49001, (616) 383-7363. **Approved for:** 8 hours Category I Credit.

21-25, 29th Annual, Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Marie McNight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400.

23, Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicide. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Tracy Baker, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 6 hours Category I Credit.

July

11-13, 7th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort Village, Grand Traverse Resort, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157. **Approved for:** 15 hours Category I Credit.

22-25, Ninteenth Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Michigan State Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, I 48106-1157, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

22-24, Advances in Office Psychiatry II: Mood and Anxiety Disorders. Location: Grand Traverse LResort, Grand Traverse Resort Village, Michigan.

Continued on following page

General Internal Medicine

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CATEGORY I COURSES

Continued from page 47

Sponsor: University of Michigan Medical School and the Michigan Psychiatric Society. **Contact:** Registrar, Office of Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 12 hours Category I Credit.

29-30, 73rd Annual Collier Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, Michigan. **Sponsor:** Munson Medical Center and Medical Staff. **Contact:** Elaine Gaines, Medical Education, Munson Medical Center, 1105 Sixth St., Traverse City, MI 49684-2386, (616) 935-6546.

August

8-11, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Marie McKnight, Towsley Center for Contiuing Medical Education, Department of Postgraduate Medicine and health Care Professions, University of Michigan Medical School, P.O. LBox 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

23-28, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Association of Pediatric Program Directors, Michigan Chapter, American Academy of Pediatrics. **Contact:** Marie McKnight, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 60 hours Category I Credit.

September

9-10, Critical Clinical Issues in the Care of the Elderly: Oral Health, Dysphagia, Aspiration and Pneumonia. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan and Cleveland Regional Medical Education Center, Department of Veteran Affairs. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 7 hours Category I Credit.

15, Diagnosis and Management of Myocardial Infarction. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

20-21, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Marie McKnight, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

22, 23, Diagnosis and Management of Myocardial Infarction. Location: September 22, Novi Hilton, Novi, Michigan. September 23, WMU Regional Center, Grand Rapids, Michigan. **Sponsor:** Michigan State Medical Society and Michigan Physicians Mutual Liability Company. **Contact:** Julie Smith, MSMS Chief, Risk Management, (517) 337-1351. **Approved for:** 6.5 hours Category I Credit.

29, Effective Compassion for the Incurably Ill: Alternatives to Assisted Suicied. Location: Holiday Inn, Flint, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Tracy Baker, Michigan State Medical Society, P.O. Box 950, East lansing, MI 48826-0950, (517) 336-5784. **Approved for:** 6 hours Category I Credit.

October

5, 6, 7, Providing Outstanding Patient Service. Location: October 5, Treasure Island, Saginaw, Michigan. October 6, Novi Hilton, Novi, Michigan. October 7, MSMS Headquarters, East Lansing, Michigan. **Sponsor:** Michigan State Medical Society. **Contact:** Office of Physician Education, (517) 336-5784. **Approved for:** 6.5 hours Category I

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PEDIATRICIAN, B.C., OR PEDIATRICIAN-INTENSIVIST to join general Pediatrician and Neonatologist-Pediatrician in N.W. Indiana. Superior schools and community, many recreational opportunities, 50 miles from Chicago. Six weeks per year PGE and vacation. Early full partnership. Send CV and cover letter to Doctors Covey and Marquez, South Ridge Pediatric Center, P.C., Suite 3, 2101 Comeford Rd., Valparaiso, Indiana, 46383.

FAMILY PRACTICE - INTERNAL MEDICINE: Excellent opportunity, Straits Area, Northern Michigan. (616) 627-9748 (evenings).

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PHYSICIANS WANTED Full-time or part-time positions available in multiple locations in the Metro Detroit area. Excellent salary and benefits, pleasant working environment. Please send C.V. to Rene' Saenz, Regional Administrator, 20755 Greenfield, Suite 900 Southfield, Michigan 48075.

WESTERN MICHIGAN Fourth internist sought to join 3-internist and 2-pulmonologist group. Salary plus benefits; partnership in second year. Dynamic metropolitan area that offers big city advantages without the problems. Wanda Parker, E.G. Todd Physician Search, 915 Broadway, Suite 1101, New York, NY 10010; 800-221-4762; Fax 212-777-5701.

MICHIGAN - EXPRESS CARE PHYSICIAN. Emergency Department in Metropolitan Hospital has opening in the Express Care Unit which services 18,000 patients per year. Ideal for energetic Family Practice Physician. Starting salary $70/hr. with incentives. Partnership available. C.V. to P.O. Box 701, Mt. Clemens, MI 48046-0701.

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PRESIDENT'S PAGE

Youth Preventative Health

Your Input is Vital

By Gilbert B. Bluhm, MD



Promotion of good health habits may provide long-term cost savings, but it is more important for quality of life. Poor lifestyle habits such as smoking, obesity, poor exercise, alcohol and drug abuse account for nearly one third of today's health care costs. It is simply easier to form good habits than to correct established bad habits.

Since May, 1992, MSMS has collaborated with Robert F. Larson, president and general manager of Detroit Public Television (WTVS-Channel 56) to develop, promote and help fund the "City For Youth Coalition" year-long media-driven programs to protect and enhance the health of children in Michigan. The initial media effort aired five evenings a week from September 28, 1992 through October 28, 1992. The media "blitz" succeeded with the help of the commercial television stations. The strategy was shaped by the conviction that attitudes and behaviors are the main determinants of health. The programs were designed to help young people take responsibility for aspects of their life that have serious consequences.

The campaign was organized around "The Four Rs of Taking Responsibility for My Life and Health":

- RESPECT for oneself, focusing on the mental health of young people.
- RESPONSIBILITY for personal conduct and future health, with an emphasis on combating substance abuse.
- RELATIONSHIPS with others, acting responsibly in sexual relationships, concerns for reproductive health.
- RISK MANAGEMENT, emphasizing violence prevention, self-protection, nonviolent conflict resolution.

The videos with an accompanying utilization guide are designed to complement the Michigan Model for Health Education and the Growing Healthy curriculum, or they can be used independently as a self-contained course. The videos are important resources for schools and youth groups throughout Michigan.

The production of 12 "one to four minute" health educational videos with teacher/discussion guide, student activity sheets and reproducible handouts were readied for distribution to every middle school (5th through 8th graders) in Michigan. I wish to emphasize that these materials reflect the contributions of youth peers to make them more appealing to a young audience. These educational materials were made possible through MSMS efforts to assist WTVS-Detroit in a $79,000 grant received earlier this year from the Michigan Health Care Education and Research Foundation.

> "I urge you to contact the middle schools where you live. Remind your PTA boards and friends that the schools have these materials. Put your prestige behind their use. You are needed for the success of this program."

A grant request for $10,000 was approved by our MSMS Health Education Foundation. Those funds permitted duplication of the videos and the distribution of the associated teaching materials to every middle school in each county of Michigan.

Some of the health topics of the 12 videos complement the domestic violence awareness initiated last year by then MSMS President Thomas C. Payne, MD. The video topics also will supplement the Healthy Youth 2000 campaign fostered by former Health and Human Services Secretary, Louis Sullivan. Also, the AMA initiated an emphasis on adolescent health that began this spring.

The videotapes and teacher's manual already have been mailed to all middle schools.

The need for local follow-up is important to stimulate use. I urge you to contact the middle schools where you live. Remind your PTA boards and friends that the schools have these materials. Put your prestige behind their use. You are needed for the success of this program.

I anticipate your assistance as we work together to accomplish "Michigan's Opportunity for Tomorrow"!

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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D3-K005

Issued: March 1993

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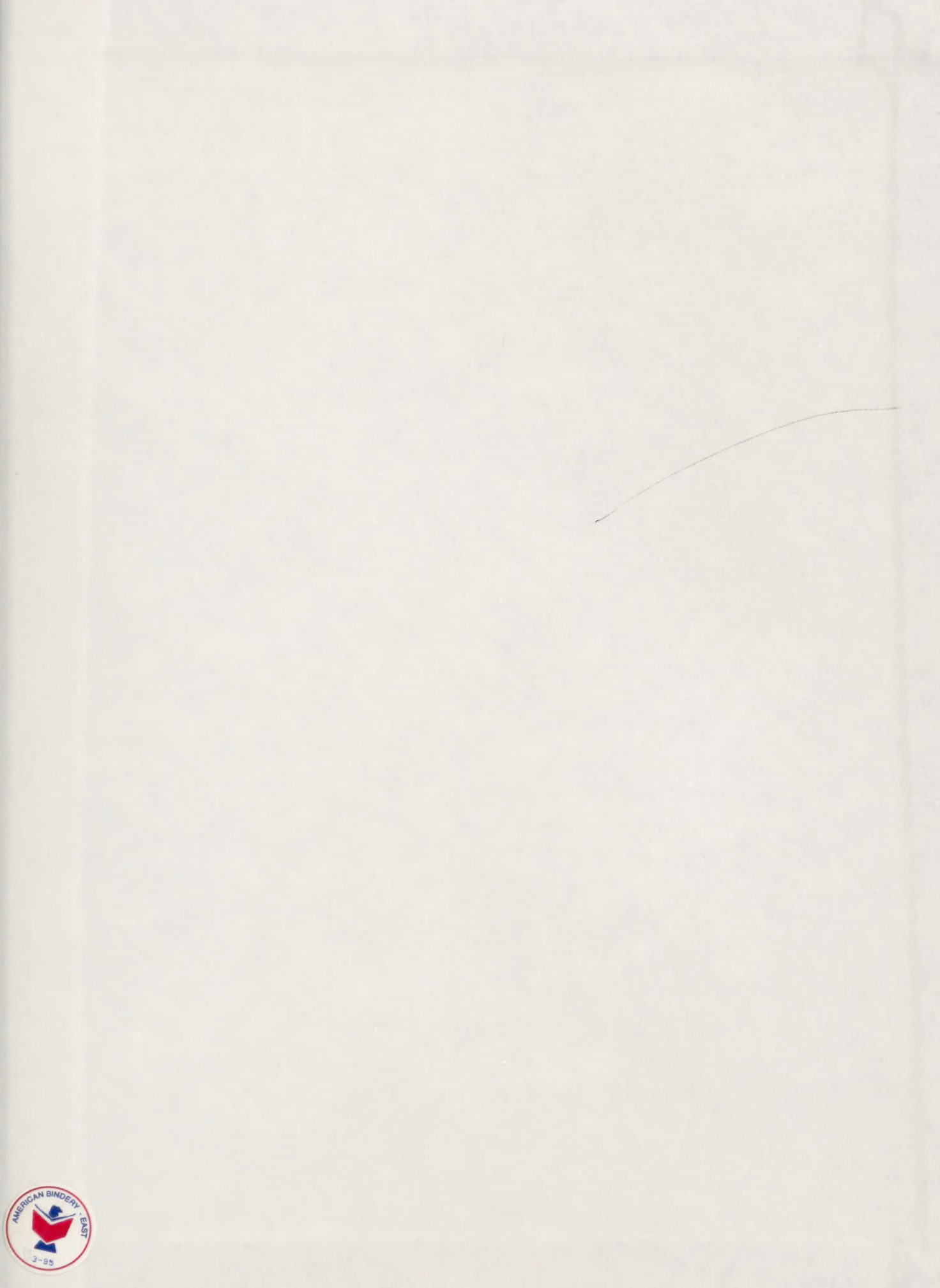
PRAVACHOL®
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PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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